107TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
107–242

DISABLED VETERANS SERVICE DOG AND HEALTH CARE IMPROVEMENT ACT OF 2001

OCTOBER 16, 2001.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. SMITH of New Jersey, from the Committee on Veterans' Affairs, submitted the following

R E P O R T

[To accompany H.R. 2792]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 2792) to amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to make service dogs available to disabled veterans and to make various other improvements in health care benefits provided by the Department of Veterans Affairs, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Disabled Veterans Service Dog and Health Care Improvement Act of 2001".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—VETERANS HEALTH CARE IMPROVEMENT

Sec. 101. Authorization for Secretary of Veterans Affairs to provide service dogs for disabled veterans.
Sec. 102. Maintenance of capacity for specialized treatment and rehabilitative needs of disabled veterans.
Sec. 103. Threshold for veterans health care eligibility means test to reflect locality cost-of-living variations.
Sec. 104. Assessment and report on special telephone services for veterans.
Sec. 105. Recodification of bereavement counseling authority and certain other health-related authorities.
Sec. 106. Extension of expiring collections authorities.

TITLE II—CHIROPRACTIC SERVICES PROGRAM

Sec. 201. Chiropractic Service established in the Veterans Health Administration.
Sec. 202. Availability of chiropractic care to veterans.
Sec. 203. Chiropractic providers.
Sec. 204. Scope of services; enrollment.
Sec. 205. Training and information.
Sec. 206. Advisory committee.
Sec. 207. Implementation report.

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TITLE III—NATIONAL COMMISSION ON VA NURSING

Sec. 301. Establishment of Commission.
Sec. 302. Duties of Commission.
Sec. 303. Reports.
Sec. 304. Powers.
Sec. 305. Personnel matters.
Sec. 306. Termination of the Commission.

TITLE I—VETERANS HEALTH CARE IMPROVEMENT

SEC. 101. AUTHORIZATION FOR SECRETARY OF VETERANS AFFAIRS TO PROVIDE SERVICE DOGS FOR DISABLED VETERANS.

(a) AUTHORITY.—Section 1714 of title 38, United States Code, is amended—

(1) in subsection (b)—

(A) by striking "seeing-eye or" the first place it appears;

(B) by striking "who are entitled to disability compensation" and inserting "who are enrolled under section 1705 of this title";

(C) by striking ", and may pay" and all that follows through "such seeing-eye or guide dogs"; and

(D) by striking "handicap" and inserting "disability"; and

(2) by adding at the end the following new subsections:

"(c) The Secretary may, in accordance with the priority specified in section 1705 of this title, provide—

"(1) service dogs trained for the aid of the hearing impaired to veterans who are hearing impaired and are enrolled under section 1705 of this title; and

"(2) service dogs trained for the aid of persons with spinal cord injury or dysfunction or other chronic impairment that substantially limits mobility to veterans with such injury, dysfunction, or impairment who are enrolled under section 1705 of this title.

"(d) In the case of a veteran provided a dog under subsection (b) or (c), the Secretary may pay travel and incidental expenses for that veteran under the terms and conditions set forth in section 111 of this title to and from the veteran's home for expenses incurred in becoming adjusted to the dog.".

(b) CLERICAL AMENDMENTS.—

(1) The heading for such section is amended to read as follows:

"§ 1714. Fitting and training in use of prosthetic appliances; guide dogs; service dogs".

(2) The item relating to such section in the table of sections at the beginning of chapter 17 of such title is amended to read as follows:

"1714. Fitting and training in use of prosthetic appliances; guide dogs; service dogs.".

SEC. 102. MAINTENANCE OF CAPACITY FOR SPECIALIZED TREATMENT AND REHABILITATIVE NEEDS OF DISABLED VETERANS.

(a) MAINTENANCE OF CAPACITY ON A SERVICE-NETWORK BASIS.—Section 1706(b) of title 38, United States Code, is amended—

(2) in paragraph (1)—

(A) in the first sentence, by inserting "(and each geographic service area of the Veterans Health Administration)" after "ensure that the Department"; and

(B) in clause (B), by inserting "(and each geographic service area of the Veterans Health Administration)" after "overall capacity of the Department"; and

(2) by redesignating paragraphs (2) and (3) as paragraphs (4) and (5), respectively;

(3) by inserting after paragraph (1) the following new paragraphs (2) and (3):

"(2) For purposes of paragraph (1), the capacity of the Department (and each geographic service area of the Veterans Health Administration) to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, traumatic brain injury, blindness, prosthetics and sensory aids, and mental illness) within distinct programs or facilities shall be measured for seriously mentally ill veterans as follows (with all such data to be provided by geographic service area and totaled nationally):

"(A) For mental health intensive community-based care, the number of discrete intensive care teams constituted to provide such intensive services to seriously mentally ill veterans and the number of veterans provided such care.

"(B) For opioid substitution programs and for traumatic brain injury, the number of patients treated annually and the amounts expended.

"(C) For dual-diagnosis patients, the number treated annually and the amounts expended.

"(D) For substance abuse programs—

"(i) the number of substance-use disorder beds (whether hospital, nursing home, or other designated beds) employed and the average bed occupancy of such beds;

"(ii) the percentage of unique patients admitted directly to substance abuse outpatient care during the fiscal year who had two or more additional visits to specialized substance abuse outpatient care within 30 days of their first visit, with a comparison from 1996 until the date of the report;

"(iii) the percentage of unique inpatients with substance abuse diagnoses treated during the fiscal year who had one or more specialized substance abuse clinic visits within three days of their index discharge, with a comparison from 1996 until the date of the report; and

"(iv) the percentage of unique outpatients seen in a facility or service network during the fiscal year who had one or more specialized substance abuse clinic visits, with a comparison from 1996 until the date of the report.

"(E) For mental health programs, the number and type of staff that are available at each facility to provide specialized mental health treatment, including satellite clinics, outpatient programs, and community-based outpatient clinics, with a trend line comparison from 1996 to the date of the report.

"(F) The number of such clinics providing mental health care, the number and type of mental health staff at each such clinic, and the type of mental health programs at each such clinic.

"(3) For purposes of paragraph (1), the capacity of the Department (and each geographic service area of the Veterans Health Administration) to provide for the specialized treatment and rehabilitative needs of disabled veterans within distinct programs or facilities shall be measured for veterans with spinal cord dysfunction, traumatic brain injury, blindness, or prosthetics and sensory aids as follows (with all such data to be provided by geographic service area and totaled nationally):

"(A) For spinal cord injury/dysfunction specialized centers and for blind rehabilitation specialized centers, the number of staffed beds and the number of full-time equivalent employees assigned to provide care at such centers.

"(B) For prosthetics and sensory aids, the annual amount expended.".

(b) EXTENSION OF ANNUAL REPORT REQUIREMENT.—Paragraph (3) of such section, as so redesignated, is amended—

(1) by striking "April 1, 1999, April 1, 2000, and April 1, 2001" and inserting "April 1 of each year through 2004"; and

(2) by adding at the end the following new sentence: "The accuracy of each such report shall be certified by, or otherwise commented upon by, the Inspector General of the Department.".

SEC. 103. THRESHOLD FOR VETERANS HEALTH CARE ELIGIBILITY MEANS TEST TO REFLECT LOCALITY COST-OF-LIVING VARIATIONS.

(a) REVISED THRESHOLD.—Subsection (b) of section 1722 of title 38, United States Code, is amended to read as follows:

"(b)(1) For purposes of subsection (a)(3), the income threshold applicable to a veteran is the amount determined under paragraph (2).

"(2) The amount determined under this paragraph for a veteran is the greater of the following:

"(A) For any calendar year after 2000—

"(i) in the case of a veteran with no dependents, $23,688, as adjusted under subsection (c); or

"(ii) in the case of a veteran with one or more dependents, $28,429, as so adjusted, plus $1,586, as so adjusted, for each dependent in excess of one.

"(B) The amount in effect under the HUD Low Income Index that is applicable in the area in which the veteran resides.

"(3) For purposes of paragraph (2)(B), the term 'HUD Low Income Index' means the family income ceiling amounts determined by the Secretary of Housing and Urban Development under section 3(b)(2) of the United States Housing Act of 1937 (42 U.S.C. 1437a(b)(2)) for purposes of the determination of 'low-income families' under that section.".

(c) CONFORMING AMENDMENT.—(1) Subsection (a)(3) of such section is amended by striking "amount set forth in" and inserting "income threshold determined under".

(2) Subsection (c) of such section is amended by striking "subsection (b)" and inserting "subsection (b)(2)(A)".

(d) LIMITATION ON RESOURCE REALLOCATIONS.— Within the amount appropriated to the Department of Veterans Affairs for medical care for each of fiscal years 2002 through 2006. the amount that would otherwise be allocated by the Secretary to any geographic service region of the Veterans Health Administration in accordance with the established resource allocation procedures of the Department may not be increased or decreased by more than 5 percent by reason of the implementation of this section.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on April 1, 2002.

SEC. 104. ASSESSMENT AND REPORT ON SPECIAL TELEPHONE SERVICES FOR VETERANS.

(a) ASSESSMENT OF CURRENT SERVICES.—The Secretary of Veterans Affairs shall carry out an assessment of all special telephone services for veterans (such as helplines and hotlines) provided by the Department of Veterans Affairs. The assessment shall include the geographical coverage, availability, utilization, effectiveness, management, coordination, staffing, and cost of those services. As part of such assessment, the Secretary shall conduct a survey of veterans to measure their satisfaction with current special telephone services and the demand for additional services.

(b) REPORT.—Not later than one year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the assessment carried out under subsection (a). The Secretary shall include in the report recommendations regarding any needed improvement to such services and recommendations regarding contracting for the performance of such services.

SEC. 105. RECODIFICATION OF BEREAVEMENT COUNSELING AUTHORITY AND CERTAIN OTHER HEALTH-RELATED AUTHORITIES.

(a) STATUTORY REORGANIZATION.—Subchapter I of chapter 17 of title 38, United States Code, is amended—

(1) in section 1701(6)—

(A) by striking subparagraph (B) and the sentence following that subparagraph;

(B) by striking "services—" in the matter preceding subparagraph (A) and inserting "services, the following:"; and

(C) by striking subparagraph (A) and inserting the following:

"(A) Surgical services.

"(B) Dental services and appliances as described in sections 1710 and 1712 of this title.

"(C) Optometric and podiatric services.

"(D) Preventive health services.

"(E) In the case of a person otherwise receiving care or services under this chapter—

"(i) wheelchairs, artificial limbs, trusses, and similar appliances;

"(ii) special clothing made necessary by the wearing of prosthetic appliances; and

"(iii) such other supplies or services as the Secretary determines to be reasonable and necessary.

"(F) Travel and incidental expenses pursuant to section 111 of this title."; and

(2) in section 1707—

(A) by inserting "(a)" at the beginning of the text of the section; and

(B) by adding at the end the following:

"(b) The Secretary may furnish sensori-neural aids only in accordance with guidelines prescribed by the Secretary.".

(b) CONSOLIDATION OF PROVISIONS RELATING TO PERSONS OTHER THAN VETERANS.—Such chapter is further amended by adding at the end the following new subchapter:

"SUBCHAPTER VIII—HEALTH CARE OF PERSONS OTHER THAN VETERANS

"§ 1782. Counseling, training, and mental health services for immediate family members

"(a) COUNSELING FOR FAMILY MEMBERS OF VETERANS RECEIVING SERVICE-CONNECTED TREATMENT.—In the case of a veteran who is receiving treatment for a service-connected disability pursuant to paragraph (1) or (2) of section 1710(a) of this title, the Secretary shall provide to individuals described in subsection (c) such consultation, professional counseling, training, and mental health services as are necessary in connection with that treatment.

"(b) COUNSELING FOR FAMILY MEMBERS OF VETERANS RECEIVING NON-SERVICE-CONNECTED TREATMENT.—In the case of a veteran who is eligible to receive treatment for a non-service-connected disability under the conditions described in paragraph (1), (2), or (3) of section 1710(a) of this title, the Secretary may, in the discre-

tion of the Secretary, provide to individuals described in subsection (c) such consultation, professional counseling, training, and mental health services as are necessary in connection with that treatment if—

"(1) those services were initiated during the veteran's hospitalization; and

"(2) the continued provision of those services on an outpatient basis is essential to permit the discharge of the veteran from the hospital.

"(c) ELIGIBLE INDIVIDUALS.—Individuals who may be provided services under this subsection are—

"(1) the members of the immediate family or the legal guardian of a veteran; or

"(2) the individual in whose household such veteran certifies an intention to live.

"(d) TRAVEL AND TRANSPORTATION AUTHORIZED.—Services provided under subsections (a) and (b) may include, under the terms and conditions set forth in section 111 of this title, travel and incidental expenses of individuals described in subsection (c) in the case of—

"(1) a veteran who is receiving care for a service-connected disability; and

"(2) a dependent or survivor receiving care under the last sentence of section 1783(b) of this title.

"§ 1783. Bereavement counseling

"(a) DEATHS OF VETERANS.—In the case of an individual who was a recipient of services under section 1782 of this title at the time of the death of the veteran, the Secretary may provide bereavement counseling to that individual in the case of a death—

"(1) that was unexpected; or

"(2) that occurred while the veteran was participating in a hospice program (or a similar program) conducted by the Secretary.

"(b) DEATHS IN ACTIVE SERVICE.—The Secretary may provide bereavement counseling to an individual who is a member of the immediate family of a member of the Armed Forces who dies in the active military, naval, or air service in the line of duty and under circumstances not due to the person's own misconduct.

"(c) BEREAVEMENT COUNSELING DEFINED.—For purposes of this section, the term 'bereavement counseling' means such counseling services, for a limited period, as the Secretary determines to be reasonable and necessary to assist an individual with the emotional and psychological stress accompanying the death of another individual.

"§ 1784. Humanitarian care

"The Secretary may furnish hospital care or medical services as a humanitarian service in emergency cases, but the Secretary shall charge for such care and services at rates prescribed by the Secretary.".

(c) TRANSFER OF CHAMPVA SECTION.—Section 1713 of such title is—

(1) transferred to subchapter VIII of chapter 17 of such title, as added by subsection (b), and inserted after the subchapter heading;

(2) redesignated as section 1781; and

(3) amended by adding at the end of subsection (b) the following new sentence: "A dependent or survivor receiving care under the preceding sentence shall be eligible for the same medical services as a veteran, including services under sections 1782 and 1783 of this title.".

(d) REPEAL OF RECODIFIED AUTHORITY.—Section 1711 of such title is amended by striking subsection (b).

(e) CROSS REFERENCE AMENDMENTS.—Such title is further amended as follows:

(1) Section 103(d)(5)(B) is amended by striking "1713" and inserting "1781".

(2) Sections 1701(5) is amended by striking "1713(b)" in subparagraphs (B) and (C)(i) and inserting "1781(b)".

(3) Section 1712A(b) is amended—

(A) in the last sentence of paragraph (1), by striking "section 1711(b)" and inserting "section 1784"; and

(A) in paragraph (2), by striking "section 1701(6)(B)" and inserting "sections 1782 and 1783".

(4) Section 1729(f) is amended by striking "section 1711(b)" and inserting "section 1784".

(5) Section 1729A(b) is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6) the following new paragraph (7):

"(7) Section 1784 of this title.".

(6) Section 8111(g) is amended—

(A) in paragraph (4), by inserting "services under sections 1782 and 1783 of this title" after "of this title,"; and

(B) in paragraph (5), by striking "section 1711(b) or 1713" and inserting "section 1782, 1783, or 1784".

(7) Section 8111A(a)(2) is amended by inserting ", and the term 'medical services' includes services under sections 1782 and 1783 of this title" before the period at the end.

(8) Section 8152(1) is amended by inserting "services under sections 1782 and 1783 of this title," after "of this title),".

(9) Sections 8502(b), 8520(a), and 8521 are amended by striking "the last sentence of section 1713(b)" and inserting "the penultimate sentence of section 1781(b)".

(f) CLERICAL AMENDMENTS.—

(1) The table of sections at the beginning of such chapter is amended—

(A) by striking the item relating to section 1707 and inserting the following:

"1707. Limitations.";

(B) by striking the item relating to section 1713; and

(C) by adding at the end the following:

"SUBCHAPTER VIII—HEALTH CARE OF PERSONS OTHER THAN VETERANS

"1781. Medical care for survivors and dependents of certain veterans.
"1782. Counseling, training, and mental health services for immediate family members.
"1783. Bereavement counseling.
"1784. Humanitarian care.".

(2) The heading for section 1707 is amended to read as follows:

"§ 1707. Limitations".

SEC. 106. EXTENSION OF EXPIRING COLLECTIONS AUTHORITIES.

(a) HEALTH CARE COPAYMENTS.—Section 1710(f)(2)(B) of title 38, United States Code, is amended by striking "September 30, 2002" and inserting "September 30, 2007".

(b) MEDICAL CARE COST RECOVERY.—Section 1729(a)(2)(E) of such title is amended by striking "October 1, 2002" and inserting "October 1, 2007".

TITLE II—CHIROPRACTIC SERVICES

SEC. 201. CHIROPRACTIC SERVICE ESTABLISHED IN THE VETERANS HEALTH ADMINISTRATION.

(a) NEW SERVICE IN VETERANS HEALTH ADMINISTRATION.—Section 7305 of title 38, United States Code, is amended—

(1) by redesignating paragraph (7) as paragraph (8); and

(2) by inserting after paragraph (6) the following new paragraph (7):

"(7) A Chiropractic Service.".

(b) DIRECTOR.—Section 7306(a) of such title—

(1) by redesignating paragraphs (7) through (10) as paragraphs (8) through (11), respectively; and

(2) by inserting after paragraph (6) the following new paragraph (7):

"(7) A Director of Chiropractic Service, who shall be a qualified doctor of chiropractic and who shall be responsible to the Secretary for the operation of the Chiropractic Service.".

SEC. 202. AVAILABILITY OF CHIROPRACTIC CARE TO VETERANS.

(a) ESTABLISHMENT.—The Secretary of Veterans Affairs shall establish a program to provide chiropractic care to veterans through all Department of Veterans Affairs medical centers.

(b) IMPLEMENTATION.—The program under this section shall be implemented at Department of Veterans Affairs medical centers as follows:

(1) At not less than 30 medical centers by the end of fiscal year 2002.

(2) At not less than 60 medical centers by the end of fiscal year 2003,

(3) At not less than 90 medical centers by the end of fiscal year 2004.

(4) At not less than 120 medical centers by the end of fiscal year 2005.

(5) At all of the Department of Veterans Affairs medical centers by the end of fiscal year 2006.

(c) INITIAL PARTICIPATING MEDICAL CENTERS.—The initial 30 medical centers at which the program is to be carried out shall be designated by the Secretary not later than 60 days after the date of the enactment of this Act. In designating those medical centers, the Secretary shall select medical centers to reflect geographic diver-

sity, facilities of various size and capabilities, and the range of services in the Department health care system.

SEC. 203. CHIROPRACTIC PROVIDERS.

The program under section 202 shall be carried out through personal service contracts and with appointments of licensed chiropractors for delivery of chiropractic services at Department of Veterans Affairs medical centers.

SEC. 204. SCOPE OF SERVICES; ENROLLMENT.

(a) SCOPE OF SERVICES.—The chiropractic services provided under section 202 shall include, at a minimum, care for neuro-musculoskeletal conditions.

(b) ENROLLMENT.—A veteran enrolled under section 1705 of title 38, United States Code, may, as part of such enrollment, choose a chiropractor as the veteran's primary care provider. A veteran with a primary care provider other than a chiropractor may be referred to chiropractic services for neuro-musculoskeletal conditions by a medical provider.

SEC. 205. TRAINING AND INFORMATION.

(a) PRIMARY CARE TEAMS.—The Secretary shall provide training and materials relating to chiropractic services to members of Department health care providers assigned to primary care teams for the purposes of familiarizing those providers with the benefits of appropriate use of chiropractic services.

(b) FUTURE PROGRAM SITES.—During the period covered by section 202(b), the Secretary shall provide materials relating to chiropractic services to medical centers and other health care facilities of the Department not yet participating in the program in order to ensure that health care providers at those facilities are aware of chiropractic care as a future referral source.

(c) APPROVAL OF MATERIALS.—The Secretary may approve materials to be furnished under subsections (a) and (b) only after consulting with, and receiving the views of, the advisory committee established under section 206.

SEC. 206. ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—The Secretary shall establish an advisory committee to review implementation of the program under this title.

(b) MEMBERS.—In appointing the members of the advisory committee, the Secretary shall include on the advisory committee—

(1) members of the chiropractic profession;

(2) persons who are experts in human resources appointments in the Federal service;

(3) persons with expertise in academic matters;

(4) persons with knowledge of credentialing and the granting of professional privileging to health care practitioners; and

(5) other persons as determined necessary by the Secretary and the functional needs of the advisory committee in establishing the chiropractic health program.

(c) FUNCTIONS.—The advisory committee shall provide advice to the Secretary on—

(1) the granting of professional privileges for chiropractors at Department medical centers;

(2) the scope of practice of chiropractors at Department medical centers;

(3) training materials; and

(4) such other matters as are determined appropriate by the Secretary.

SEC. 207. IMPLEMENTATION REPORT.

Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to the Committees on Veterans Affairs of the Senate and House of Representatives a report on the implementation of this title.

TITLE III—NATIONAL COMMISSION ON VA NURSING

SEC. 301. ESTABLISHMENT OF COMMISSION.

(a) ESTABLISHMENT.—There is hereby established in the Department of Veterans Affairs a commission to be known as the "National Commission on VA Nursing" (hereinafter in this title referred to as the "Commission").

(b) COMPOSITION.—(1) The Commission shall be composed of 12 members.

(2) Eleven members shall be appointed by the Secretary of Veterans Affairs, as follows:

(A) Three shall be recognized representatives of employees, including nurses, of the Department of Veterans Affairs.

(B) Three shall be representatives of professional associations of nurses of the Department or similar organizations affiliated with the Department's health care practitioners.

(C) Two shall be representatives of trade associations representing the nursing profession.

(D) Two shall be nurses from nursing schools affiliated with the Department of Veterans Affairs.

(E) One shall be a representative of veterans.

(3) The Nurse Executive of the Department of Veterans Affairs shall be an ex officio member of the Commission.

(d) CHAIRMAN OF COMMISSION.—The Secretary of Veterans Affairs shall designate one of the members of the Commission to serve as chairman of the Commission.

(e) PERIOD OF APPOINTMENT; VACANCIES.—Members shall be appointed for the life of the Commission. Any vacancy in the Commission shall be filled in the same manner as the original appointment.

(f) INITIAL ORGANIZATION REQUIREMENTS.—All appointments to the Commission shall be made not later than 60 days after the date of the enactment of this Act. The Commission shall convene its first meeting not later than 60 days after the date as of which all members of the Commission have been appointed.

SEC. 302. DUTIES OF COMMISSION.

(a) ASSESSMENT.—The Commission shall—

(1) consider legislative and organizational policy changes to enhance the recruitment and retention of nurses by the Department of Veterans Affairs; and

(2) assess the future of the nursing profession within the Department.

(b) RECOMMENDATION.—The Commission shall recommend legislative and organizational policy changes to enhance the recruitment and retention of nurses in the Department.

SEC. 303. REPORTS.

(a) COMMISSION REPORT.—The Commission shall, not later than two years after the date of its first meeting, submit to Congress and the Secretary of Veterans Affairs a report on the Commission's findings and conclusions.

(b) SECRETARY OF VETERANS AFFAIRS REPORT.—Not later than 60 after the date of the Commission's report under subsection (a), the Secretary shall submit to Congress a report—

(1) providing the Secretary's views on the Commission's findings and conclusions; and

(2) explaining what actions, if any, the Secretary intends to take to implement the recommendations of the Commission and the Secretary's reasons for doing so.

SEC. 304. POWERS.

(a) HEARINGS.—The Commission or, at its direction, any panel or member of the Commission, may, for the purpose of carrying out the provisions of this title, hold hearings and take testimony to the extent that the Commission or any member considers advisable.

(b) INFORMATION.—The Commission may secure directly from any Federal department or agency information that the Commission considers necessary to enable the Commission to carry out its responsibilities under this title.

SEC. 305. PERSONNEL MATTERS.

(a) PAY OF MEMBERS.—Members of the Commission shall serve without pay by reason of their work on the Commission.

(b) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(c) STAFF.—(1) The Secretary may, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, appoint a staff director and such additional personnel as may be necessary to enable the Commission to perform its duties.

(2) The Secretary may fix the pay of the staff director and other personnel appointed under paragraph (1) without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay fixed under this paragraph for the staff director may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title and the rate of pay for other

personnel may not exceed the maximum rate payable for grade GS–15 of the General Schedule.

(d) DETAIL OF GOVERNMENT EMPLOYEES.—Upon request of the Secretary, the head of any Federal department or agency may detail, on a nonreimbursable basis, any personnel of that department or agency to the Commission to assist it in carrying out its duties.

SEC. 306. TERMINATION OF THE COMMISSION.

The Commission shall terminate 90 days after the date of the submission of its report under section 303(a).

INTRODUCTION

The reported bill, in the nature of a substitute to H.R. 2792, the Disabled Veterans Service Dog and Health Care Improvement Act of 2001, reflects the Committee's consideration of matters necessary to make a number of improvements in the Department of Veterans Affairs health care programs.

On April 3, 2001, the Subcommittee on Health held a hearing concerning the current state of the VA health care system. Those testifying at the hearing included: the Honorable Thomas L. Garthwaite, Under Secretary for Health, Department of Veterans Affairs; Dr. Frances M. Murphy, Deputy Undersecretary for Health, Department of Veterans Affairs; Dr. John G. Clarkson, Senior Vice President Medical Affairs and Dean, University of Miami School of Medicine, Miami, FL; Dr. George Thibault, Chairman, Special Medical Advisory Group, Department of Veterans Affairs, Vice President and Chairman of Clinical Affairs, Partners Health Care, Inc.; Mr. James R. Fischl, Director, National Veterans Affairs and Rehabilitation Commission, The American Legion; Mr. Paul A. Hayden, Associate Director, National Legislative Service, Veterans of Foreign Wars; Ms. Joy J. Ilem, Assistant National Legislative Director, Disabled American Veterans; Mr. John Bollinger, Deputy Executive Director, Paralyzed Veterans of America; Mr. Richard Jones, National Legislative Director, AMVETS; Mr. Bobby J. Harnage, Sr., National President, American Federation of Government Employees; Ms. Ellen M Pitts, R.N., President, VA Medical Center, Brockton, MA, Local R1–187, National Association of Government Employees; and Ms. Elaine Gerace, R.N., Divisional President, VA Medical Center, Syracuse, NY, Local 200B, Service Employees International Union.

On June 20, 2001, the Subcommittee on Health held a hearing on mental health, substance use disorders, and homelessness in the veteran population, and the Department's policies in dealing with these difficult challenges. Those testifying at the hearing included: the Honorable Thomas Garthwaite, Under Secretary for Health, Department of Veterans Affairs; Mr. Peter H. Dougherty, Director, Homeless Veterans Programs, Office of Public and Intergovernmental Affairs, Department of Veterans Affairs; Dr. Paul Errera, Connecticut VA Health System, Former Director, VHA Mental Health and Behavioral Sciences; Dr. Laurent S. Lehmann, Chief Consultant, Mental Health and Behavioral Sciences Services, Department of Veterans Affairs; Dr. Miklos Losonczy, New Jersey VA Health System Co-chair, VA Advisory Committee on Serious Mental Illness; Dr. Richard McCormick, Ohio VA Health System, Co-chair, VA Advisory Committee on Serious Mental Illness; Dr. Bruce Rounsaville, Connecticut VA Health System, Professor of Psychiatry, Yale University; Ms. Linda Boone, Executive Director, Na-

tional Coalition for Homeless Veterans; Dennis Culhane, Ph.D., Associate Professor, University of Pennsylvania, Fred Frese, Ph.D., Chair, Veterans Committee, National Alliance for the Mentally Ill; Mr. Ralph Ibson, Vice President for Government Affairs, National Mental Health Association; Mr. Richard Fuller, National Legislative Director, Paralyzed Veterans of America; Ms. Joy Ilem, Assistant National Legislative Director, Disabled American Veterans; Ms. Linda Spoonster-Schwartz, Associate Research Scientist, Yale University School of Nursing; and Mr. Richard Weidman, Executive Director, Government Relations, Vietnam Veterans of America.

On September 6, 2001, the Subcommittee on Health, Committee on Veterans' Affairs held a legislative hearing on H.R. 2792, the Disabled Veterans Service Dog and Health Care Improvement Act of 2001. Those testifying at the hearing included: the Honorable Lois Capps, U.S. House of Representatives; the Honorable Dave Weldon, U.S. House of Representatives; the Honorable Roger Wicker, U.S. House of Representatives; Ms. Beth Barkley, Vice President, A Rinty for Kids, Inc., (with service dogs "Rin Tin Tin #8", "Fearghas", and "Gustav"); the Honorable Anthony J. Principi, Secretary of Veterans Affairs, Department of Veterans Affairs; Dr. Frances Murphy, Deputy Under Secretary for Health, Department of Veterans Affairs; Mr. Richard Fuller, National Legislative Director, Paralyzed Veterans of America; Ms. Joy Ilem, Assistant National Legislative Director, Disabled American Veterans; Mr. Thomas H. Miller, Executive Director, Blinded Veterans Association; and Ms. Jacqueline Garrick, Deputy Director, American Legion; and Mr. Richard Jones, National Legislative Director, AMVETS.

On September 24, 2001, the Subcommittee on Health held a hearing in Wichita, Kansas, on health systems and health care related issues and concerns. Those testifying at the hearing included: Mr. James R. Franklin, Vietnam Veteran, Liberal, Kansas; Mr. Olen Mitchell, World War II Veteran, Hutchinson, Kansas; Mr. Scott Ratzlaff, Desert Storm Veteran, Colby, Kansas; Ms. Tamina Fromme, Vietnam Veteran, Dodge City, Kansas; Mr. Kent Hill, Director, VA Medical and Regional Office Center, Wichita, Kansas; Dr. L.S. Raju, VA Community Based Outpatient Clinic, Liberal, Kansas; Ms. Leann Zimmerman, Nurse Practitioner, VA Community Based Outpatient Clinic, Hays, Kansas; Dr. Peter Almenoff, VISN 15 Network Medical Director, VA Heartland Network, Kansas City, Missouri.

Through these hearings, meetings and through other mechanisms of oversight, the Subcommittee and full Committee on Veterans Affairs considered the following bills: H.R. 2792; H.R. 1136; H.R. 1435; and H.R. 936, dealing with a variety of matters pertaining to health care, specialized resources and human services offered to the Nation's veterans by the Department of Veterans Affairs and other agencies of the federal government.

On October 4, 2001, the Subcommittee on Health met and unanimously ordered H.R. 2792 reported favorably to the full Committee with an amendment in the nature of a substitute.

On October 10, 2001, the full Committee met and ordered H.R. 2792 reported favorably to the House with an amendment in the nature of a substitute by voice vote.

SUMMARY OF THE REPORTED BILL

H.R. 2792, as amended, would:

1. Authorize service dogs be provided by VA to a veteran suffering from spinal cord injuries or dysfunction, other diseases causing physical immobility, hearing loss or other types of disabilities susceptible to improvement or enhanced functioning in activities of daily living through employment of a service dog. A veteran would be required to be enrolled in VA care as a prerequisite to eligibility for a service dog. Service dogs would be provided in accordance with existing priorities for all VA health care enrollment.
2. Strengthen the mandate for VA to maintain capacity in specialized medical programs for veterans by requiring each Veterans Integrated Service Network to maintain a proportional share of national capacity in certain specialized health care programs for veterans (those with serious mental illness, including substance use disorders, spinal cord, brain injured and blinded veterans; veterans who need prosthetics and sensory aids); and extend capacity reporting requirement for 3 years.
3. Modify VA's system of determining nonservice-connected veterans' "ability to pay" for VA health care services by introducing (generally as an upper income bound compared to current income limits) the "Low Income Housing Index" employed by the Department of Housing and Urban Development (HUD). This index is used to determine family income thresholds for HUD housing assistance eligibility. This index is adjusted for all Standard Metropolitan Statistical Areas (SMSA), and is updated periodically by HUD to reflect economic changes within the SMSAs. This change in law would be phased in with no VISN experiencing greater than 5 percent change in funding allocation than would otherwise occur.
4. Require the Secretary of Veterans Affairs to assess all special telephone services made available to veterans, such as "help lines" and "hotlines." The assessment would include geographical coverage, availability, utilization, effectiveness, management, coordination, staffing, cost, and a survey of veterans to measure effectiveness of these telephone services and future needs. A report to Congress would be required within 1 year of enactment.
5. Extend expiring authority for VA to collect proceeds from veterans' health insurance policies for care provided for non-service connected care.
6. Establish a VA chiropractic services program, to be implemented in a 5-year period; authorize VA to employ chiropractors as federal employees and obtain chiropractic services through contracts; create a VA advisory committee on chiropractic health care; authorize chiropractors to function as VA primary care providers; authorize appointment of a director of chiropractic service reporting to the Secretary, with the same authority as other service directors in the VA health care system.

7. Establish a National Commission on VA nursing, consisting of 12 members appointed by the Secretary; their review would include legislative and organizational policy changes to enhance recruitment and retention of nurses and assess future of the nursing profession in the VA; a report to Congress would be required within 2 years of establishment.

BACKGROUND AND DISCUSSION

Authorization for Service Dogs for Disabled Veterans.—The Department of Veterans Affairs (VA) is authorized to provide blinded veterans with guide dogs to aid them in adjusting to blindness and severe vision impairments. Many veterans who are enrolled in VA health care are suffering from mobility or hearing impairments would benefit greatly from use of service dogs, but VA is not authorized to furnish assistive animals under current law. A service dog would not only provide a companion to the disabled veteran, but could also reduce the amount of time and resources needed from an aide for activities of daily living.

With proper training, service dogs can perform tasks such as opening and closing doors, turning switches on and off, assisting a person from a sitting or lying position, providing help in and out of bathtubs or showers, picking up and retrieving objects, pulling wheelchairs, or helping a person with clothing, including helping to dress and undress. The benefits service dogs provide are well known and documented in medical journals, studies, and personal testimony. The testimony received at the Subcommittee's hearing on September 6, 2001, supported extending this special benefit to enrolled veterans.

The reported bill expands the authority of the Department of Veterans Affairs to provide service dogs to veterans, but in accordance with current enrollment priorities. In the Committee's view, section 101 would strengthen VA benefits to hearing impaired and mobility-impaired veterans to improve the quality of life.

Maintenance of Capacity in Specialized Programs.—Congress provided a mandate in legislation (Public Law 104–262) that requires VA to maintain nationwide capacity to provide for specialized treatment and rehabilitative needs for veterans, including those with amputations, spinal cord injury or dysfunction, traumatic brain injury, and severe, chronic, disabling mental illnesses, including schizophrenia, PTSD and substance-use disorders. To validate VA's compliance with capacity maintenance, the legislation requires an annual report to Congress. The emphasis in the law is clearly on VA *maintaining* specialized capacity, including appropriate VA inpatient care and VA intensive-case management—approaches that a number of studies have shown to be more effective than primary care in the treatment of persons with mental illnesses. There is little question that primary care costs less, but its effectiveness as a substitute for these traditional VA programs for its most vulnerable patients is still uncertain.

The Committee has been made well aware that there have been recurring problems with VA's observance of the capacity law, and the most recent report submitted to the Congress by VA confirms their continued existence. According to the report, the three largest problems center on: 1) lack of confidence in VA's own data; 2) in-

ability to identify VA patients receiving care in specialized programs, and 3) lack of outcome measures to assess program effectiveness. Several years of these reports, all claiming the same kinds of continuing data and definitional difficulties, causes the Committee to question whether VA is in full compliance with the law. The report requirement was designed to ensure that Congress has a fair and frank depiction of resource investment in VA's mental health, drug abuse, blind rehabilitation, and other specialized care programs. The Congress recognizes that optimal treatment modalities may change over time, but has directed the Secretary to ensure that overall capacity for service delivery is not lost.

The Committee's bill would strengthen the requirement for VA to maintain capacity by applying the requirement both nationally and to the 22 Veterans Health Administration patient care networks. The Committee bill would also add new reporting requirements to better elucidate for Congress VA's changing capacity to provide and maintain care systems for the most seriously mentally ill and substance-addicted patients; veterans who need prosthetics and sensory aids services; and programs in spinal cord injury and blind rehabilitation, among others.

Threshold for Means Test to Reflect Cost of Living.—Section 103 of the Committee bill would modify the "means test" employed by the Department of Veterans Affairs to determine eligible veterans' enrollment priority, as set forth in section 1722 of title 38, United States Code. Enrollment priority is important because veterans in lower categories (*i.e*., VA priority levels 6 and 7) whose incomes are above current means test levels (in 2001, $23,688 per year for a single veteran) are required to make co-payments for their care. These copayments must be made for hospitalization (the current Medicare first-day deductible of $792 plus $10.00 per day); nursing home care (one-half the Medicare hospitalization first-day deductible for each 90 days plus $5.00 per day); outpatient services ($50.80 per day); and pharmaceutical services ($2.00 for each 30-day supply of medication). The Secretary of Veterans Affairs is authorized to limit veterans' enrollment and access to VA health services because of budgetary limitations.

VA's national income threshold is insensitive to regional variations in cost of living, cost of health care, cost of housing, employment factors, rural or urban influences and other matters that determine or heavily affect an individual veterans' ability to pay. One method of ensuring equity for veterans in access to VA health care would be adjustment of the national means test by locality, to more accurately reflect well-recognized differences in geographic cost-of-living.

The HUD low-income limits are established under Section 3 of the U.S. Housing Act of 1937, as amended. HUD income limits are currently used to determine eligibility in 22 separate federal programs, including a number of tax incentive programs. Although HUD acknowledges that its income estimates are not completely reliable for every metropolitan area, it regularly corrects estimating errors and assesses data sources for the most reliable and up-to-date information. The limits are a viable method to aid VA in establishing a proxy for a veteran's ability to pay on a regional basis. HUD defines "low income" families as those with incomes that do not exceed 80 percent of the median family incomes for the

areas in which they reside. Limits are established for 2,680 geographic areas, including Metropolitan Statistical Areas (MSAs), Primary Metropolitan Statistical Areas (PMSAs) and counties.

Using the HUD low-income limits in place of VA's current means test threshold would mean that all veterans residing in a defined locality would have a means test threshold adjusted to reflect the cost-of-living determined for that particular defined area. This new threshold would be more indicative of the veteran's ability to defray the cost of care. Furthermore, to ensure that no veterans would be dislodged from Category 5 into Category 7 and thus compelled to make copayments, when these new thresholds were implemented, the bill would maintain the existing national income threshold as the lowest figure for any means test variation, even if the HUD formula were to determine in a given instance that the low-income rate for a particular area is actually below the VA's national income threshold. This would provide assurance that existing category 5 veterans would not be affected by the application of the HUD limits, but some current "higher income" veterans whose incomes now place them above the margin would move to category 5 as a consequence of the new means test system.

Use of the HUD low-income rates to augment VA's current, single means test standard would create a more realistic, equitable system to reflect cost-of-living variations from one locality to another. This new methodology would affirm Congressional intent that VA provide care for poor veterans on a high-priority basis.

To address concerns about the potential effect of using the alternative HUD low-income limits on VA's internal allocation system, the bill includes a provision that no VHA geographic service area's allocation could be increased or decreased by more than 5 percent in any year due to the application of the HUD limits in determination of a veterans' priority of enrollment in VA care.

Assessment and Report on Special Telephone Services.—The Committee is concerned about the status of the variety of telephone services VA may be making available to veterans in both its health care and benefits programs, and in particular, any telephone "hotlines" or "help lines" focused on providing information to veterans who may be in crisis or who are homeless and in need of urgent services or information. Section 104 directs the Secretary to study the availability, utilization, effectiveness, and cost of these VA services. The study would include a survey of veterans who have used such services in the past as to whether they are satisfied with the current availability of services and the demand for additional services. The study should assess VA capabilities to offer local referrals for the provision of emergency shelter and food for homeless veterans, VA substance use disorder rehabilitation sources, opportunities for employment and training, and small business assistance programs, if appropriate.

The report of the Secretary would be required within 180 days of enactment of the Committee's bill.

Extension of Collections Authorities.—VA is authorized to retain third-party recoveries and other co-payments from the provision of health-care services to certain non-service connected veterans and to use those resources to provide additional care to veterans. This authority allows VA necessary flexibility to enhance funding

through user fees that Congress would otherwise have to provide through appropriations.

Since this fund was restructured in the Balanced Budget Act of 1997, enabling VA to retain and expend funds thus collected, the Department has in fact retained $139.5 million in fiscal year 1997, $560.1 million in fiscal year 1998, $573.6 million in fiscal year 1999, and $563.8 million in fiscal year 2000. The Department estimates that it will retain $675 million in fiscal year 2001. Extending the authority to collect third-party insurance proceeds for care provided to service-connected veterans for non-service connected conditions to September 30, 2007, will allow VA to continue providing health care to many enrolled veterans.

Chiropractic Services in the Department of Veterans' Affairs.—Title II of the bill establishes a new chiropractic health benefit within the Department of Veterans Affairs. The Committee believes the Department is long overdue in establishing a firm, comprehensive policy to provide a full scope of chiropractic service to veterans. Over the last 106 years, chiropractic health science has become the third-largest physician-level health care profession in the world. Doctors of chiropractic are licensed in all 50 states as health care service providers.

The Committee bill would establish chiropractic services immediately in the Department, but would provide a 5-year phase-in period to enable the health care facilities of the Department to fully implement the national program. A minimum of 30 VA medical centers would be required to make chiropractic services available to veterans annually, beginning in 2002, so that all VA medical centers will be providing chiropractic services within 5 years of enactment of the Committee bill. The Committee bill specifically directs VA to activate a chiropractic service for veterans through both direct employment of doctors of chiropractic and by obtaining their services for veterans through available contracting mechanisms.

The Committee bill also requires the establishment of a national office of chiropractic, headed by an appointed Director, who shall be appointed within 90 days of enactment, and who reports to the Secretary of Veterans Affairs. The establishment of a chiropractic service in the Department will be guided by an advisory committee on chiropractic, whose members shall included chiropractors, human resources specialists and others whose expertise will facilitate optimal establishment of chiropractic within the health benefits available to veterans.

National Commission on VA Nursing.—Title III of H.R. 2792 would establish a national VA commission on nursing. The Committee, through meetings and other interactions with VA officials, reports from associations representing the nursing and allied nursing professions, reports and hearings from other committees of the House and Senate, and from reports and testimony of the General Accounting Office, is aware of a conundrum concerning the present state of nursing in the Department of Veterans Affairs, as well as the future of nursing in the United States. To better assist the Committee and Congress in dealing with necessary actions to sustain a dependable source of nursing staff for the VA health care system, the bill authorizes the establishment of an independent na-

tional nursing commission. This body is to include representatives of trade associations, professional associations representing VA nurses, unions and academic nursing. It should reflect the full spectrum of nursing professionals within the Department.

The commission will be required to assemble and meet as an independent activity, assess the current and projected supply and demand of nursing professionals, review any relevant reports or assessments from available literature, consult as necessary with academic institutions, the Secretary, elements of the Veterans Health Administration and other health care providers, and report to Congress within 2 years its findings, conclusions and recommendations. The report would be required to be reviewed by the Secretary of Veterans Affairs, and the Secretary would be required to report VA's views and recommendations on the national commission's report within 60 days of its receipt.

SECTION-BY-SECTION ANALYSIS

Section 1. Short Title

Section 1(a) declares the title of this Act to be the "Disabled Veterans Service Dog and Health Care Improvement Act of 2001." Section 1(b) sets forth the table of contents, including Title I, Veterans Health Care Improvement; Title II, Chiropractic Services Program; and Title III, National Commission on VA Nursing.

TITLE I—VETERANS HEALTH CARE IMPROVEMENT

Section 101. Authorization for Secretary of Veterans Affairs to provide Service Dogs for Disabled Veterans

Section 101 would amend the existing law to expand the Department's authority to provide guide dogs to blind veterans. Current law limits the provision of guide dogs to blind veterans who are entitled to disability compensation. The bill removes that language, and provides the benefit to all enrolled veterans. This provision would also authorize the Department to provide service dogs to veterans who are hearing impaired or who have spinal cord injury or dysfunction or other chronic impairment that substantially limits mobility. The provision states that these services are to be provided in accordance with the priority specified in section 1705.

Existing statutory authority allows the Department to pay for certain travel and incidental expenses incurred by veterans while adjusting to guide dogs. Section 101 would amend the language to allow these expenses for all guide dogs or service dogs covered by this legislation.

Section 102. Maintaining Capacity

Section 102 addresses the Department's statutory obligation to maintain the capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans, including veterans with spinal cord dysfunction, blindness, amputations, and mental illness. Congress imposed this requirement with the enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104–262. The law requires that capacity be maintained at its 1996 level. The bill would amend the statute to require that the Department maintain this capacity not only in the Department as a

whole, but within each geographic service area, or VISN, of the Veterans Health Administration.

Section 102 would amend 38 U.S.C. § 1706(b) to provide detail on how VA is to measure the capacity to provide specialized treatment and rehabilitative needs of disabled veterans within distinct programs or facilities. It states that the distinct programs or facilities must be measured for seriously ill veterans in different ways for different types of services provided. All of the data must be provided by geographic service area and totaled nationally.

For mental health intensive community-based care, capacity is to be measured by the number of discrete intensive care teams constituted to provide such intensive services to seriously mentally ill veterans and the number of veterans provided such care. For opioid substitution programs and for traumatic brain injury, capacity is to be measured by the number of patients treated annually and the amounts expended. For dual-diagnosis patients, capacity is to be measured by the number treated annually and the amounts expended. For substance abuse programs, capacity is to be measured by four different measures. First, it is measured by the number of substance-use disorder beds employed (hospital, nursing home or other designated beds) and the average bed occupancy of such beds. The second measure is the percentage of unique patients admitted directly to substance abuse outpatient care during the fiscal year who had two or more additional visits to specialized substance abuse outpatient care within 30 days of their first visit, with a comparison from 1996 until the date of the report. The third measure is the percentage of unique inpatients with substance abuse diagnoses treated during the fiscal year who had one or more specialized substance abuse clinic visits within three days of their index discharge, with a comparison from 1996 until the date of the report. Finally, the fourth measure of capacity for substance abuse programs is the percentage of unique outpatients seen in a facility or service network during the fiscal year who had one or more specialized substance abuse clinic visits, with a comparison from 1996 until the date of the report. For mental health programs, capacity is to be measured by the number and type of staff that are available at each facility to provide specialized mental health treatment, including satellite clinics, outpatient programs, and community-based clinics, with a trend line comparison from 1996 to the date of the report. The measurement should indicate the number of clinics providing mental health care, the number and type of mental health staff at each such clinic, and the type of mental health programs at each such clinic. For spinal cord injury specialized centers and for blind rehabilitation specialized centers, capacity is to be measured by the number of beds in the centers, and by the number of staff assigned on a full-time basis to provide care in such centers. For prosthetics and sensory aids, capacity is to be measured by the annual amount expended.

The Department's obligation to report on compliance with this requirement is extended through 2004. Section 102 adds a new requirement that the Inspector General of the Department certify or comment on the accuracy of each such capacity report.

Section 103.—Means Test Threshold

Section 103 would amend 38 U.S.C. § 1722 to establish new geographically based income thresholds for determining a non-service-connected veteran's priority for receiving VA care and whether the veteran must agree to pay copayments in order to receive that care. It would utilize low-income limits developed by the Department of Housing and Urban Development (HUD) to establish these alternative income thresholds. The income threshold for the veteran would be either the specific income threshold set forth on a national basis, or the low-income limits set by HUD—whichever is greater.

Section 103 also includes a limitation on resource allocation by capping the amount of money that can be reallocated because of this provision. Within the amount appropriated to the Department for medical care for each of fiscal years 2002 through 2006, the amount that would otherwise be allocated by the Secretary to any geographic service region of the Veterans Health Administration in accordance with the established resource allocation procedures of the Department may not be increased or decreased by more than 5 percent because of this new provision.

Section 104.—Assessment and Report on Special Telephone Services for Veterans

Section 104 is a provision that requires the Secretary to assess all special telephone services for veterans (such as help lines and hotlines) provided by the Department. The assessment will include the geographic coverage, availability, utilization, effectiveness, management, coordination, staffing, and cost of those services. The assessment must also include a survey of veterans to measure satisfaction with the current special telephone services, as well as the demand for additional services. The Secretary shall submit a report to Congress on the assessment no later than one year after the enactment of this bill. The report must include recommendations regarding any needed improvement to the services, and recommendations regarding contracting for such services.

Section 105.—Recodification of Bereavement Counseling and other Authorities

Section 105 would amend chapter 17 of title 38, United States Code to consolidate and reorganize without substantive change, in a new subchapter, all of the various legal authorities under which VA provides services to non-veterans. It would reorganize 38 U.S.C. § 1701 by transferring one provision (pertaining to sensori-neural aids) to section 1707.

Section 105 would create a new Subchapter VIII in Chapter 17 to incorporate provisions concerning counseling and bereavement counseling services for family members. The new subchapter would include a section on VA's provision of counseling, training and mental health services for family members of veterans who are receiving certain service-connected and non-service-connected treatment.

A new section 1782 provides counseling, training, and mental health services for immediate family members. Subsection (a) of section 1782 states that in the case of a veteran who is receiving treatment for a service-connected disability pursuant to paragraph

(1) or (2) of section 1710(a), the Secretary shall provide to individuals described in subsection (c) such consultation, professional counseling, training, and mental health services as are necessary in connection with that treatment. Subsection (b) of section 1782 states that in the case of a veteran who is eligible to receive treatment for a non-service-connected disability under certain conditions, the Secretary may, in the discretion of the Secretary, provide to individuals described in subsection (c) such consultation, professional counseling, training, and mental health services as are necessary in connection with that treatment if those services were initiated during the veteran's hospitalization; and if the continued provision of those services on an outpatient basis is essential to permit the discharge of the veteran from the hospital. Subsection (c) of section 1782 identifies eligible individuals who may be provided services as members of the immediate family or the legal guardian of a veteran; or the individual in whose household such veteran certifies an intention to live. Subsection (d) allows certain travel and transportation expenses of eligible individuals.

Section 105 would also recodify the Secretary's authority to provide bereavement counseling following the death of certain veterans. Subsection (a) of the new Section 1783 states that in the case of an individual who was a recipient of services under section 1782 of this title at the time of the death of the veteran, the Secretary may provide bereavement counseling to that individual in the case of a death that was unexpected; or that occurred while the veteran was participating in a hospice program (or a similar program) conducted by the Secretary. Subsection (b) states that the Secretary may provide bereavement counseling to an individual who is a member of the immediate family of a member of the Armed Forces who dies in the active military, naval, or air service in the line of duty and under circumstances not due to the person's own misconduct. Subsection (c) states that the term 'bereavement counseling' means such counseling services, for a limited period, as the Secretary determines to be reasonable and necessary to assist an individual with the emotional and psychological stress accompanying the death of another individual. The counseling described in section 1782 and 1783 are currently authorized in the definition of outpatient medical services.

Section 105 would place in the new subchapter the current dependent health care authorities (transferred from current section 1713 to the new section 1781). A new provision in the bill provides that a dependent or survivor receiving VA-sponsored care would also be eligible for the bereavement counseling and the other counseling, training and mental health services provided to family members under this new subchapter.

The existing authority to provide hospital care or medical services as a humanitarian service in emergency cases would be moved to this new subchapter from the current location in section 1711(b).

Section 105 also makes various technical changes to accommodate the reorganization. These changes would recodify the currently existing provisions, and consolidate and clarify the existing statutory authority to provide care to non-veterans.

Section 106.—Extension of Expiring Collections Authorities

Section 106 would amend sections 1710(f)(2)(B) and 1729(a)(2)(E) of title 38, United States Code, to extend VA's authority to collect per diem nursing home and hospital co-payments from certain veterans, and to collect third-party payments for the treatment of the nonservice-connected disabilities of veterans with service-connected disabilities.

TITLE II – CHIROPRACTIC SERVICES

Section 201.—Chiropractic Service Established in the Veterans Health Administration

Section 201 amends 38 U.S.C. section 7305 to create a new position of Director of Chiropractic Service. The Director of the service is to be a qualified doctor of chiropractic and is responsible to the Secretary for the operation of the Chiropractic Service.

Section 202.—Availability of Chiropractic Care to Veterans

Section 202 requires the Secretary to establish a program to provide chiropractic care in all Veterans Affairs medical centers. The provision phases in the program by requiring a chiropractic service at not less than 30 medical centers by the end of fiscal year 2002; at not less than 60 medical centers by the end of fiscal year 2003; at not less than 90 medical centers by the end of fiscal year 2004; and not less than 120 medical centers by the end of fiscal year 2005; and at all medical centers by the end of fiscal year 2006. The Secretary shall designate the initial 30 medical centers not later that 60 days after the date of enactment of this provision. The Secretary must select medical centers to reflect geographic diversity, facilities of various size and capabilities, and the range of services within medical centers in the Department health care system.

Section 203.—Chiropractic Providers

Section 203 states that the program under section 202 shall be carried out through personal service contracts and with appointments of licensed chiropractors for delivery of chiropractic services at Department of Veterans Affairs medical centers.

Section 204—Scope of Services; Enrollment

Section 204 stipulates that the chiropractic services provided under section 202 shall include, at a minimum, care for neuro-musculoskeletal conditions. Veterans enrolled for care under section 1705 of title 38, United States Code, may choose a chiropractor as the veteran's primary care provider. Veterans with a primary care provider other than a chiropractor may be referred to chiropractic services for neuro-musculoskeletal conditions by another primary care provider.

Section 205.—Training and Information

Section 205 requires the Secretary to provide training and materials relating to chiropractic services to members of Department health care providers assigned to primary care teams in order to familiarize those providers with the benefits of appropriate use of chiropractic services. During the phase-in period described in section 202, the Secretary is required to provide materials relating to

chiropractic services to medical centers and other health care facilities of the Department that are not participating in the program in order to ensure that health care providers at non-participating facilities are aware of chiropractic care as a future referral source.

Section 206.—Advisory Committee

Section 206 directs the Secretary to establish an advisory committee to review the implementation of the chiropractic program in Department medical facilities. In appointing members to the advisory committee, that Secretary shall include members of the chiropractic profession; persons who are experts in human resources appointments in the Federal service; persons with expertise in academic matters; persons with knowledge of credentialing and the granting of professional privileging to health care practitioners; and other persons determined necessary by the Secretary and the functional needs of the advisory committee in establishing the chiropractic health program. The advisory committee shall provide advice to the Secretary on the granting of professional privileges for chiropractors at Department medical centers; the scope of practice of chiropractors at Department medical centers; training materials; and such other matters as are determined appropriate by the Secretary.

Section 207.—Implementation Report

No later than 18 months after the date of the enactment of this bill, the Secretary shall submit to the Committees on Veterans Affairs of the Senate and House of Representatives a report on the implementation of this title.

TITLE III—NATIONAL COMMISSION ON VA NURSING

Section 301.—Establishment of Commission

Section 301 establishes a commission known as the "National Commission on VA Nursing." The commission is to be composed of 12 members. Eleven members shall be appointed by the Secretary. They include three recognized representatives of employees, including nurses, of the Department; three representatives of professional associations of nurses of the Department or similar organizations affiliated with the Department's health care practitioners; two representatives of trade associations representing the nursing profession; two nurses from nursing schools affiliated with the Department; and one representative of veterans. The twelfth member, the Nurse Executive of the Department, is be an ex officio member of the commission. The Secretary shall designate one of the members to serve as chairman of the Commission. Members shall be appointed for the life of the Commission. Any vacancy will be filled in the same manner as the original appointment. The appointments are to be made no later that 60 days after enactment of this Act. The Commission shall convene its first meeting not later than 60 days after the date as of which all members of the Commission have been appointed.

Section 302.—Duties of the Commission

Section 302 describes the duties of the Commission. The Commission is to assess legislative and organizational policy changes to en-

hance the recruitment and retention of nurses by the Department, and the future of the nursing profession within the Department, and recommend legislative and organization policy changes to enhance the recruitment and retention of nurses in the Department.

Section 303.—Reports

Section 303 states that the Commission shall submit to Congress and the Secretary a report on its findings and conclusions. The report is due no later than two years after the date of the first meeting of the Commission. Not later than 60 days after the date of the Commission's report, the Secretary shall submit a report to Congress. The Secretary's report to Congress shall provide the Secretary's views on the Commission's findings and conclusions. It shall explain what actions, if any, the Secretary intends to take to implement the recommendations of the Commission, and the Secretary's reasons for doing so.

Section 304.—Powers

Section 304 states that the Commission or, at its direction, any panel or member of the Commission, may hold hearings and take testimony to the extent that the Commission or any member considers it advisable to do so. The Commission may secure directly from any agency or department information that the Commission considers necessary to enable it to carry out its responsibilities under this title.

Section 305.—Personnel Matters

Section 305 states that the members of the Commission shall serve on the Commission without pay. While performing services for the Commission away from their homes or regular places of business, Commission members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies.

The Secretary may appoint a staff director and such additional personnel as may be necessary to enable the Commission to perform its duties. The appointment may be made without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The Secretary may fix the pay of the staff director and the personnel without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to the classification of positions and General Schedule pay rates. The pay fixed for the staff director may not exceed the rate payable for level V of the Executive Schedule under section 5316 of title 5, United States Code, and the rate of pay for other personnel may note exceed the maximum rate payable for grade GS–15 of the General Schedule.

Upon the request of the Secretary, the head of any Federal department or agency may detail, on a nonreimbursable basis, any personnel of that department or agency to the commission.

Section 306.—Termination of the Commission

The Commission shall terminate 90 days after the date of the submission of its report.

PERFORMANCE GOALS AND OBJECTIVES

The reported bill would authorize health care benefits enhancements for veterans and VA program improvements, and require certain assessments and reports to Congress. It would extend VA's specialized medical care capacity reporting for three years and specify detailed reporting requirements. It would require a VA assessment and report within one year of enactment on VA's specialized telephone services for veterans. It would establish a VA chiropractic services program over a five year period and require a report on implementation within 18 months after enactment. It also would establish a National Commission on VA Nursing that would be required to assess recruitment and retention of nurses, and assess the future of the nursing profession in the VA, with a report required within two years of establishment. These programs, assessments and reports are subject to the Committee's regular oversight.

STATEMENT OF THE VIEWS OF THE ADMINISTRATION

STATEMENT OF ANTHONY J. PRINCIPI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS, ON PROPOSED LEGISLATION, BEFORE THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES HOUSE OF REPRESENTATIVES, SEPTEMBER 6, 2001

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here this morning to comment on H. R. 2792, the "Disabled Veterans Service Dog and Health Care Improvement Act of 2001." If enacted, this bill would authorize the Secretary of Veterans Affairs to make service dogs available to disabled veterans and to make various other changes in health care benefits provided by the Department of Veterans Affairs. This morning I would like to briefly summarize the various sections of the bill, and provide VA's views of these sections.

Section 2—Service Dogs

The bill would amend the existing law to expand VA's authority to provide guide dogs to blind veterans. Current law limits the provision of guide dogs to blind veterans who are entitled to disability compensation. The bill removes that limitation and would authorize VA to provide service dogs to veterans who are hearing impaired or who have spinal cord injury or dysfunction or other chronic impairment that substantially limits mobility. Service dogs can assist a disabled person in his or her daily life and can assist that person during medical emergencies. They can be trained in many tasks, including, but not limited to, pulling a wheelchair, carrying a back-pack, opening and closing doors, helping with dressing and undressing, retrieving dropped items, picking up the telephone, and hitting a distress button on the telephone. Some service dogs can perceive when the disabled individual is in distress and can find help. Dogs can also assist the hearing impaired by alerting them to doorbells, ringing phones, smoke detectors, crying babies, and emergency sirens on vehicles.

The existing statutory authority allows VA to pay for certain travel and incidental expenses incurred by veterans while adjusting to seeing-eye or guide dogs. The bill would amend the language to allow VA to pay these expenses for all guide dogs or service dogs covered by this legislation.

Mr. Chairman, the benefit of guide dogs for the blind is well known, and we support having authority to also provide service dogs for veterans who are hearing impaired and who have spinal cord injuries or other chronic impairments, and to pay for certain costs associated with adjusting to the dogs. However, we believe the provision of guide dogs and service dogs should continue to be limited to veterans who are entitled to service-connected compensation. If this provision becomes law, we would promulgate prescription criteria and guidelines to insure that we provide dogs only to those veterans who can most benefit from them.

Section 3—Maintaining Capacity

Section 3 of the bill addresses VA's statutory obligation to maintain the capacity to provide for the specialized treatment and rehabilitative needs of disabled vet-

erans, including veterans with spinal cord dysfunction, blindness, amputations, and mental illness. As you know, Mr. Chairman, Congress imposed this requirement with the enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104–262. The law requires that capacity be maintained at its 1996 level. The bill would amend the statute to require that VA maintain this capacity not only in the Department as a whole, but within each geographic service area, or VISN, of the Veterans Health Administration. Additionally, the bill adds new language stating that the capacity to provide specialized treatment and rehabilitative needs of disabled veterans within distinct programs or facilities must be measured by the annual amount spent for the care of such veterans in dedicated programs that provide these services through specialized staff. VA's obligation to report on compliance with this requirement is extended through 2004.

Mr. Chairman, we do not object to the provision which would require maintenance of capacity within each geographic service area. This provision is consistent with our desire to ensure that there is equality of access to quality specialized services. However, in order to accomplish this, we propose that the capacity be based on the enrolled veteran population in each geographic service area. In addition, we oppose the provision that would measure capacity by dollars expended. The cost of care is not an adequate measure, by itself, to demonstrate whether VA is maintaining the quality of and access to specialized care. Cost alone is not a valid and reliable measure of capacity. Limiting the capacity report to measurement of dollars expended will neither indicate nor ensure that VA is upholding its commitment to these high priority patients. Capacity must be measured by the actual number of patients receiving care in the specialized programs, the quality of the care provided, patients' health outcomes, and patients' access to that care, including waiting times for appointments.

Furthermore, Mr. Chairman, it is currently not possible to know whether the amount of care and the dollars expended in 1996 were optimal for measuring capacity in the targeted special programs. The care provided in 1996 provides only a snapshot of what was then a rapidly changing VA health care delivery system. It is not clear that 1996 can or should serve as a baseline out to 2004, as proposed by this bill.

We understand that the staff of the Senate Veterans Affairs' Committee is developing a different position with regard to VA's obligation to maintain capacity. We would be happy to work with both the Senate and House staff on this issue to develop amendments that would allow us to provide the best possible information on VA's capacity for treating veterans with specialized treatment and rehabilitative needs.

Section 4—Means Test Threshold

Mr. Chairman, section 4 would establish new geographically based income thresholds for VA to use in determining a non-service-connected veteran's priority for receiving VA care and whether the veteran must agree to pay copayments in order to receive that care. This would be an alternative to the threshold presently set by statute. As you know, Mr. Chairman, the law now requires that most veterans enroll in our health care system in order to receive care. Enrollees are placed in an enrollment priority group that is based, in many instances, on their level of income and net worth. Although we currently provide care to veterans in all enrollment priority groups, if there were medical care funding shortages in the future, it might be necessary to determine that those non-service connected veterans with relatively higher incomes must be disenrolled, meaning they could no longer receive VA care. Current law establishes, on a National basis, the specific income thresholds that we must use to determine the priority group of any given enrollee with no service-connected disability or other special status. We place higher income veterans in priority group 7 and lower income veterans in priority group 5.

This provision would establish a new, geographically based income threshold that VA could use for placing veterans in priority groups. It would utilize a poverty index developed by the Department of Housing and Urban Development (HUD) to establish this alternative income threshold. The income threshold for the veteran would be either the specific income thresholds set forth on a National basis, or the amount set forth by the HUD index—whichever is greater. In most instances, this new income threshold would be greater than the current statutory income threshold used for determining whether a veteran should be placed in priority group 5.

We are very interested in examining the use of geographically based income thresholds for placing nonservice-connected veterans in different enrollment priority groups. We recognize that the cost of living in large urban areas is much greater than in many more rural parts of the country. What might be considered a reasonably high income in some locations may be totally inadequate in other higher cost locations. However, at this time we cannot support the specific methodology pro-

posed in this bill. There are many poverty indices that are established in various ways, and there are serious issues about what these indexes really measure. We believe further study is needed to determine the most appropriate method for tackling this problem.

We are currently reviewing the various poverty indices in order to identify the best way to proceed. We expect to have this work completed in September. We would be happy to work with staff members from the Congressional Committees to consider the alternative indices and other changes to ensure that the means test for VA health care is equitable and affords reasonable access to VA health care services.

Section 5—Pilot Program for Coordination of Ambulatory Community Hospital Care

Section 5 is a provision that is essentially the same as a measure passed by the House of Representatives last year despite the strong opposition of VA. The provision would establish a pilot program entitled "Coordination of Hospital Benefits Program." The program would authorize special benefits for some veterans receiving care in a VA outpatient clinic who need hospital care. Under the program, veterans with third-party health plan coverage (including Medicare and Medicaid) may receive different hospital care benefits from those without third-party coverage. Veterans with no third-party coverage of any sort would be offered hospital care in the nearest VA hospital with the ability to provide care. That facility may not be particularly close to where the veteran resides. On the other hand, veterans with third-party coverage would be offered a choice. First, they could choose to use the nearest VA hospital. Alternatively, they could choose to use a private facility, with VA paying for certain costs, such as the health plan deductible, coinsurance, or the cost of inpatient care or medical services that are not covered by the health plan.

The pilot program would be open only to veterans to whom VA "shall" furnish care, essentially all enrollees except those in enrollment priority group 7. To be eligible, the veterans must also meet certain additional conditions. Specifically, participants must be enrolled to receive medical services from a VA outpatient clinic, require hospital care for a non service-connected condition that could not be provided by a clinic operated by VA and elect to receive such care under the non-VA health care plan. The program would be limited to veterans who have received VA care during the 24-month period preceding the veteran's application to enroll in the pilot program. In designating the geographic areas in which to establish the program, VA must ensure that at least 70 percent of the veterans who reside in a designated area reside at least two hours' driving distance from the closest VA medical center.

The provision also limits expenditures for the pilot program to $50 million in any fiscal year. Moreover, funds from the proposal must come from the Medical Care Collections Fund and no funds may be used that are otherwise available for treating veterans requiring specialized care.

We strongly oppose this proposed pilot program. The proposal would create a disparate eligibility status based on a veteran's third-party coverage and priority group. We are also concerned that the program would undermine our ability to maintain existing services, especially specialized medical services and programs for veterans. Limiting care to general medical and surgical services would mean that veterans needing specialty health services would still need to come to VA for care. The health care covered by this proposal would be inpatient care for non-service-connected conditions. A veteran currently receiving care for a service-connected condition, for which VA does not or cannot contract locally, would also be forced to receive care in multiple locations. These types of disparities are not consistent with our goals and strategies of improving access, convenience, and timeliness of VA health care to all eligible veterans.

Funding for the program would be drawn from the Medical Care Collections Fund (MCCF). The Fund's collections, which are available to VA facilities to support current VA-provided medical care, would be reduced by this provision. MCCF collections supplement the dollars appropriated for medical care and are a necessary component of VHA's budget. Use of MCCF funds for this pilot would negatively impact care for veterans not enrolled in the pilot. In addition, this provision may affect the Medicare Trust Fund.

The bill would also require that not less that 15 percent of the veterans participating in the pilot program are veterans who do not have a health-care plan. This requirement is confusing, as the purpose of the pilot program is to allow VA to pay for the out of pocket costs that veterans incur through non-VA health plans. It is not clear how VA would achieve this goal for veterans who have no other health care plan. The 15 percent limit might be a false floor or ceiling, depending on the actual number of veterans at a particular pilot site that have no insurance. This could affect the potential outcomes of the pilot. If there are a large number of insured veterans, the out-of-pocket expense covered by VA would be less that the ex-

pense of covering the full care provided to an uninsured veteran. This could make the pilot look financially successful. On the other hand, if the number of non-insured veterans is high, the expenses could make the pilot program less financially viable.

The bill also defines the term "health-care plan" by cross-reference to section 1725(f). The bill states that the term "health-care plan" has the meaning given that term in section 1725(f)(3). However, the referenced section does not define the term health plan or health-care plan, but rather defines the term "third party" for purposes of reimbursement for emergency treatment. We believe that this reference might be an error, and that the intended reference was to section 1725(f)(2). Section 1725(f)(2) defines the term "health-plan contract" which includes, among other things, Medicare and Medicaid plans.

Section 6— Pilot Program for Contract Hospitalization and Fee Basis Ambulatory Care

This section of the bill would require the Secretary to conduct a three-year pilot program in which veterans receiving fee basis and contract hospitalization would be provided such care through a contractor who acts as a managed care coordinator. The provision states that the program shall be conducted in four selected geographical areas that have mature managed care markets. To the extent practicable all fee basis and contract hospitalization provided by VA in the selected geographical service areas would be provided through the contractor. The contractor must be an experienced managed care coordinator with an in-place network of credentialed providers. All enrolled veterans in a selected geographical service area who are authorized to use non-VA care services through fee basis programs of the Department, or who are eligible for contract hospitalization, would be automatically enrolled for participation in the pilot program. Once approved to receive non-VA fee basis care, or when they seek care for a health emergency, participants would be given a directory of health care providers from which to choose.

In conducting the pilot program, VA would be required to use standards (commercial-industry or, in their absence, Department standards) for measuring access, timeliness, patient satisfaction, and utilization management. The contractor must establish a toll-free telephone system staffed by registered nurses to provide advice and health care referral information to veterans enrolled in the pilot program on a 24-hour a day, seven-day a week basis, and a veterans service telephone line for the provision of information on eligibility, enrollment, and provider locations. The program also must provide concurrent review, demand management, disease management and health and wellness programs.

Each medical center participating in the program must have a primary care manager. The primary care manager at each VA facility would be responsible for the coordination and case management of each enrolled veteran who is participating in the pilot program to ensure that such veterans receive the appropriate care, and that veterans are brought back into the VA system for follow-up whenever possible and appropriate. The pilot program includes extensive reporting requirements by VA, and a mandatory review by the Comptroller General.

> We are interested in a pilot program to examine the costs and benefits of operating our fee basis program in a new manner; however, we are concerned about some of the restrictive requirements in this specific provision. For example, we would like ensure that VA retains clinical control with respect to the type of care that the patient receives, as well as the amount of care authorized. We would also want to ensure that the costs of any contract would be no more than the current cost for the fee basis program in the selected locations. Finally, we believe that it would be appropriate for VA to continue to provide the toll-free telephone system providing information on eligibility, enrollment and provider locations. We would be pleased to work with staff members of the Committee to consider alternative language that would allow VA the flexibility to evaluate alternative delivery systems without some of the limitations and requirements mandated by this provision.

Section 7—Recodification of Bereavement Counseling and other Authorities

Mr. Chairman, section 7 of the bill would consolidate, in a new subchapter of title 38, United States Code, all of the various legal authorities under which VA provides services to non-veterans. The new subchapter would include a section on VA's provision of counseling, training and mental health services for family members of veterans who are receiving treatment. It would also include a section on bereavement counseling following the death of certain veterans. Both types of counseling are currently authorized in the definition of outpatient medical services. This change will make the authority much clearer.

The authority under which we provide CHAMPVA benefits, presently section 1713 of title 38, would be transferred to this new subchapter. A new provision in the bill provides that a dependent or survivor receiving CHAMPVA care would also be eligible for the bereavement counseling and the other counseling, training and mental health services provided to family members under this new subchapter. Finally, the existing authority to provide hospital care or medical services as a humanitarian service in emergency cases would be moved to this new subchapter.

The proposed changes would recodify the currently existing provisions. We support this change, as it would consolidate and clarify the existing statutory authority to provide care to non-veterans.

Section 8—Extension of Expiring Collections Authorities

Mr. Chairman, this final provision would amend title 38 to extend VA's authority to collect per diem nursing home and hospital co-payments from certain veterans, and to collect third-party payments for the treatment of the nonservice-connected disabilities of veterans with service-connected disabilities. We strongly support and welcome the extensions proposed in this section. These collections constitute an important and necessary supplement to our annual appropriations.

Mr. Chairman, this ends my statement. I will be pleased to answer any questions you may have.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

The following letter was received from the Congressional Budget Office concerning the cost of the reported bill:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 12, 2001.

Hon. CHRISTOPHER H. SMITH
Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 2792, the Disabled Veterans Service Dog and Health Care Improvement Act of 2001.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sam Papenfuss, who can be reached at 226–2840.

Sincerely,

DAN L. CRIPPEN,
Director.

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

H.R. 2792, DISABLED VETERANS SERVICE DOG AND HEALTH CARE IMPROVEMENT ACT OF 2001, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON VETERANS' AFFAIRS ON OCTOBER 10, 2001

SUMMARY. H.R. 2792 would provide expanded benefits for some veterans and would consolidate several existing provisions of law that authorize health care for nonveterans into one chapter of Title 38 of the U.S. Code. The bill would direct the Department of Veterans Affairs (VA) to calculate the income thresholds for determining whether a veteran qualifies for free health care on a regional basis rather than using a single national level. The bill also would require the VA to provide chiropractic care at all VA medical centers by 2006. Finally, H.R. 2792 would extend the authority for VA to collect certain payments from both veterans and insurance companies.

H.R. 2792 would authorize funding or modify provisions governing discretionary spending for veterans' programs, which CBO estimates would result in additional outlays of about $390 million in 2002 and more than $3 billion over the 2002–2006 period, assuming appropriation of the necessary amounts. Because the bill would not affect direct spending or receipts, pay-as-you-go procedures would not apply.

H.R. 2792 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments.

ESTIMATED COST TO THE FEDERAL GOVERNMENT. The estimated budgetary impact of H.R. 2792 is shown in the following table. This estimate assumes the legislation will be enacted near the start of calendar year 2002, that the necessary funds for implementing the bill will be provided for each year, and that outlays will follow historical spending patterns for existing or similar programs. The costs of this legislation fall within budget function 700 (veterans benefits and services).

Table 1. Estimated Budgetary Impact of H.R. 2792

	By Fiscal Year, in Millions of Dollars					
	2001	2002	2003	2004	2005	2006
Spending Under Current Law for Veterans' Medical Care						
Estimated Authorization Level [1]	20,863	21,866	22,110	22,839	23,547	24,285
Estimated Outlays	20,418	21,501	22,020	22,613	23,298	24,028
Proposed Changes						
Income Threshold						
Estimated Authorization Level	0	420	550	680	700	710
Estimated Outlays	0	380	530	660	690	700
Chiropractic Care						
Estimated Authorization Level	0	15	34	61	89	133
Estimated Outlays	0	13	32	57	86	128
Offsetting Collections						
Estimated Authorization Level	0	0	0	0	0	0
Estimated Outlays	0	0	−85	−25	−15	−16
Total Changes						
Estimated Authorization Level	0	435	584	741	789	843
Estimated Outlays	0	393	477	692	761	812
Spending Under S. 1188						
Estimated Authorization Level	20,863	22,301	22,694	23,580	24,336	25,128
Estimated Outlays	20,418	21,894	22,497	23,305	24,059	24,840

[1] The 2001 level is the estimated net amount appropriated for that year. The current-law amounts for the 2002–2006 period assume that appropriations remain at the 2001 level, with adjustments for inflation.

Income Threshold. Under current law, VA furnishes free medical care to veterans who meet certain eligibility requirements-one of which is an income threshold. Any veteran who is eligible for Medicaid, who receives a VA pension, or who has an income below a statutory level (currently $23,688 for a veteran without a dependent) can receive free health care. Under the bill, veterans eligible for low-income housing also would qualify for free medical care. In general, the Department of Housing and Urban Development sets

eligibility for low-income housing at 80 percent of each county's median income with adjustments for cost-of-living.

This provision would affect both veterans who currently receive medical care from VA and those who do not currently use VA health care services. CBO estimates that the total cost associated with expanding eligibility for free VA medical care would be $380 million in 2002 and about $3 billion over the 2002–2006 period, assuming appropriation of the estimated amounts.

Current VA Health Care Users.—Using data from VA and the Current Population Survey, CBO estimates that under this provision about 1.4 million veterans would become eligible for free health care. CBO estimates that this number includes more than 250,000 veterans who currently use VA medical facilities but are not presently eligible for free health care. Under the bill, these veterans would no longer need to make copayments when receiving health care benefits. Because individuals use more health care services when they do not face any out-of-pocket costs, the cost of providing medical care would increase for those users who become eligible for free health care. Using data from VA and from published research, CBO estimates that those veterans receiving free health care would cost VA about $700 more per person in 2002. Using that information and adjusting for inflation, CBO estimates that providing free health care to veterans currently using VA would cost about $170 million in 2002 and almost $1 billion over the 2002–2006 period, assuming appropriation of the estimated amounts.

Because the veterans discussed above would be eligible for free health care, VA also would lose the copayments that these veterans make when receiving care. CBO estimates that the lost copayments would total about $40 million over the 2002–2006 period.

New VA Health Care Users.—CBO also estimates that some veterans who do not currently use VA medical facilities because of the requirement to make copayments would do so once they became eligible for free health care. Currently, only about 20 percent of veterans eligible for free health care based on income actually use VA medical facilities. CBO expects that an even lower percentage of those who would become eligible for free health care would end up using VA medical facilities, because some of those veterans have access to health care from other sources. CBO estimates that eventually about 100,000 newly eligible veterans would begin using VA medical care at a cost of more than $4,000 per person. CBO estimates that providing free health care to these veterans would cost $210 million in 2002 and about $2 billion over the 2002–2006 period, assuming appropriation of the estimated amounts.

Chiropractic Care. Under current policy, VA does not employ chiropractors and VA spends less than $500,000 a year for veterans who see chiropractors outside of a VA hospital. Title II of H.R. 2792 would require that VA provide chiropractic care to veterans at all of its medical centers. Under the bill, VA would have to provide chiropractic services in at least 30 medical centers by the end of fiscal year 2002 and in all 172 medical centers by the end of fiscal year 2006. In addition to seeking chiropractic care for specific problems, veterans also would be able to choose a chiropractor as their primary health care provider, instead of a medical doctor.

In order to provide chiropractic care at its medical centers, VA would need to physically modify each medical center and purchase basic chiropractic equipment. Extrapolating from a Department of Defense (DoD) report that analyzed the costs of a pilot program that provided chiropractic care at military hospitals, CBO estimates that the start-up costs for providing chiropractic care at VA medical centers would average a little more than $100,000 per center. Additionally, based on the DoD experience and given the scope of potential chiropractic usage, CBO estimates that each medical center would need to provide a minimum of four chiropractors along with the necessary support personnel. CBO estimates that it would cost almost $800,000 in 2002 to staff and operate a chiropractic center. Accounting for both the gradual implementation under the bill and a two-year adjustment period for each medical center, CBO estimates that implementing title II would cost $13 million in 2002 and $316 million over the 2002–2006 period, assuming appropriation of the estimated amounts.

Offsetting Collections. Under current law VA has the authority to bill third-party insurance for veterans with a service-connected disability who receive care that is not related to the service-connected disability. VA also has the authority to collect a $10 daily payment for hospital stays and a $5 daily payment for nursing home stays from all veterans who do not qualify for free healthcare. Both of these authorities expire on September 30, 2002. These collections are currently deposited into the Medical Care Collections Fund (MCCF). Under current law, amounts deposited to the MCCF are considered to be offsets to discretionary appropriations and spending from the MCCF is subject to annual appropriations. Section 107 would extend these authorities through September 30, 2007.

Based on information from VA, CBO estimates that in 2001 VA will collect more than $190 million from third-party insurance companies and about $3 million from the daily payments. Accounting for inflation and increased usage, CBO estimates that implementing this provision would increase offsetting collections deposited to the MCCF by $213 million in 2003 and $907 million over the 2003–2006 period.

Subject to annual appropriations, VA can spend the money in the MCCF to provide medical care for veterans. CBO estimates that implementing section 107 would increase discretionary spending on medical care for veterans by $128 million in 2003 and $766 million over the 2003–2006 period, assuming appropriation of the collected amounts. Because CBO assumes that VA will spend the collections, the estimated budget authority for collections and spending offset each other exactly, while the outlays lag behind spending.

Service Dogs. H.R. 2792 would authorize VA to provide service dogs to veterans with certain disabilities. According to information from VA, the department does not actually provide the service dogs but serves as an intermediary between eligible veterans and the nonprofit organizations that train the service dogs. Because these organizations typically pay for the travel and training costs associated with a veteran receiving a guide dog, CBO estimates that this provision would have no budgetary impact.

PAY-AS-YOU-GO CONSIDERATIONS: None

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT .H.R. 2792 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

PREVIOUS CBO ESTIMATES. On September 10, 2001, CBO prepared an estimate for S. 1188, the Department of Veterans Affairs Medical Programs Enhancement Act of 2001, as ordered reported by the Senate Committee on Veterans' Affairs on August 2, 2001. The provision relating to determining income thresholds for free medical care is the same in both bills. H.R. 2792 also includes a requirement for chiropractic care and extends the authority for VA to collect certain payments from veterans and insurance companies, while S. 1188 does not. S. 1188, in turn, provides increased benefits to VA employees which H.R. 2792 does not.

ESTIMATE PREPARED BY:

Federal Costs: Sam Papenfuss.

Impact on State, Local, and Tribal Governments: Elyse Goldman.

Impact on the Private Sector: Allison Percy.

ESTIMATE APPROVED BY:

Robert A. Sunshine, Assistant Director for Budget Analysis

STATEMENT OF FEDERAL MANDATES

The preceding Congressional Budget Office cost estimate states that the bill contains no intergovernmental or private sector mandates as defined in the Unfunded Mandates Reform Act.

APPLICABILITY TO LEGISLATIVE BRANCH

The reported bill would not be applicable to the legislative branch under the Congressional Accountability Act, Public Law 104–1, because the bill would only affect certain Department of Veterans Affairs programs and benefits recipients.

STATEMENT OF CONSTITUTIONAL AUTHORITY

Pursuant to Article I, section 8 of the United States Constitution, the reported bill is authorized by Congress' power to "provide for the common Defense and general Welfare of the United States."

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

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PART I—GENERAL PROVISIONS

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CHAPTER 1—GENERAL

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§ 103. Special provisions relating to marriages

(a) * * *

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(d)(1) * * *

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(5) Paragraphs (2) and (3) apply with respect to benefits under the following provisions of this title:

(A) * * *

(B) Section [1713] *1781*, relating to medical care for survivors and dependents of certain veterans.

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PART II—GENERAL BENEFITS

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CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

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SUBCHAPTER I—GENERAL

Sec.
1701. Definitions.
* * * * * * *
[1707. Restriction on use of funds for assisted suicide, euthanasia, or mercy killing.]
1707. Limitations.
* * * * * * *

SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

* * * * * * *
[1713. Medical care for survivors and dependents of certain veterans.
[1714. Fitting and training in use of prosthetic appliances; seeing-eye dogs.]
1714. Fitting and training in use of prosthetic appliances; guide dogs; service dogs.
* * * * * * *

SUBCHAPTER VIII—HEALTH CARE OF PERSONS OTHER THAN VETERANS

1781. Medical care for survivors and dependents of certain veterans.
1782. Counseling, training, and mental health services for immediate family members.
1783. Bereavement counseling.
1784. Humanitarian care.

SUBCHAPTER I—GENERAL

§ 1701. Definitions

For the purposes of this chapter—

(1) * * *

* * * * * * *

(5) The term "hospital care" includes—

(A) * * *

(B) such mental health services, consultation, professional counseling, and training for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of a veteran or dependent or survivor of a veteran receiving care under the last sentence of section [1713(b)] *1781(b)* of this title; and

(C)(i) medical services rendered in the course of the hospitalization of a dependent or survivor of a veteran receiving care under the last sentence of section [1713(b)] *1781(b)* of this title, and (ii) travel and incidental expenses for such dependent or survivor under the terms and conditions set forth in section 111 of this title.

(6) The term "medical services" includes, in addition to medical examination, treatment, and rehabilitative [services—] *services, the following:*

[(A)(i) surgical services, dental services and appliances as described in sections 1710 and 1712 of this title, optometric and podiatric services, preventive health services, and (in the case of a person otherwise receiving care or services under this chapter) wheelchairs, artificial limbs, trusses, and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as the Secretary determines to be reasonable and necessary, except that the Secretary may not furnish sensori-neural aids other than in accordance with guidelines which the Secretary shall prescribe, and (ii) travel and incidental expenses pursuant to the provisions of section 111 of this title; and

[(B)(i) such consultation, professional counseling, training, and mental health services as are necessary in connection with the treatment—

[(I) of the service-connected disability of a veteran pursuant to paragraph (1) or (2) of section 1710(a) of this title, and

[(II) in the discretion of the Secretary, of the non-service-connected disability of a veteran eligible for treatment under paragraph (1), (2) or (3) of section 1710(a) of this title where such services were initiated during the veteran's hospitalization and the provision of such services on an outpatient basis is essential to permit the discharge of the veteran from the hospital,

[for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of the veteran (including, under the terms and conditions set forth in section 111 of this title, travel and incidental expenses of such family member or individual in the case of a veteran who is receiving care for a service-connected disability, or in the case of a dependent or

survivor of a veteran receiving care under the last sentence of section 1713(b) of this title); and

[(ii) in the case of an individual who was a recipient of services under subclause (i) of this clause at the time of—

[(I) the unexpected death of the veteran; or

[(II) the death of the veteran while the veteran was participating in a hospice program (or a similar program) conducted by the Secretary,

[such counseling services, for a limited period, as the Secretary determines to be reasonable and necessary to assist such individual with the emotional and psychological stress accompanying the veteran's death.]

(A) Surgical services.

(B) Dental services and appliances as described in sections 1710 and 1712 of this title.

(C) Optometric and podiatric services.

(D) Preventive health services.

(E) In the case of a person otherwise receiving care or services under this chapter—

(i) wheelchairs, artificial limbs, trusses, and similar appliances;

(ii) special clothing made necessary by the wearing of prosthetic appliances; and

(iii) such other supplies or services as the Secretary determines to be reasonable and necessary.

(F) Travel and incidental expenses pursuant to section 111 of this title.

* * * * * * *

§ 1706. Management of health care: other requirements

(a) * * *

(b)(1) In managing the provision of hospital care and medical services under such section, the Secretary shall ensure that the Department *(and each geographic service area of the Veterans Health Administration)* maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veterans in a manner that (A) affords those veterans reasonable access to care and services for those specialized needs, and (B) ensures that overall capacity of the Department *(and each geographic service area of the Veterans Health Administration)* to provide such services is not reduced below the capacity of the Department, nationwide, to provide those services, as of October 9, 1996. The Secretary shall carry out this paragraph in consultation with the Advisory Committee on Prosthetics and Special Disabilities Programs and the Committee on Care of Severely Chronically Mentally Ill Veterans.

(2) For purposes of paragraph (1), the capacity of the Department (and each geographic service area of the Veterans Health Administration) to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, traumatic brain injury, blindness, prosthetics and sensory

aids, and mental illness) within distinct programs or facilities shall be measured for seriously mentally ill veterans as follows (with all such data to be provided by geographic service area and totaled nationally):

(A) For mental health intensive community-based care, the number of discrete intensive care teams constituted to provide such intensive services to seriously mentally ill veterans and the number of veterans provided such care.

(B) For opioid substitution programs and for traumatic brain injury, the number of patients treated annually and the amounts expended.

(C) For dual-diagnosis patients, the number treated annually and the amounts expended.

(D) For substance abuse programs—

(i) the number of substance-use disorder beds (whether hospital, nursing home, or other designated beds) employed and the average bed occupancy of such beds;

(ii) the percentage of unique patients admitted directly to substance abuse outpatient care during the fiscal year who had two or more additional visits to specialized substance abuse outpatient care within 30 days of their first visit, with a comparison from 1996 until the date of the report;

(iii) the percentage of unique inpatients with substance abuse diagnoses treated during the fiscal year who had one or more specialized substance abuse clinic visits within three days of their index discharge, with a comparison from 1996 until the date of the report; and

(iv) the percentage of unique outpatients seen in a facility or service network during the fiscal year who had one or more specialized substance abuse clinic visits, with a comparison from 1996 until the date of the report.

(E) For mental health programs, the number and type of staff that are available at each facility to provide specialized mental health treatment, including satellite clinics, outpatient programs, and community-based outpatient clinics, with a trend line comparison from 1996 to the date of the report.

(F) The number of such clinics providing mental health care, the number and type of mental health staff at each such clinic, and the type of mental health programs at each such clinic.

(3) For purposes of paragraph (1), the capacity of the Department (and each geographic service area of the Veterans Health Administration) to provide for the specialized treatment and rehabilitative needs of disabled veterans within distinct programs or facilities shall be measured for veterans with spinal cord dysfunction, traumatic brain injury, blindness, or prosthetics and sensory aids as follows (with all such data to be provided by geographic service area and totaled nationally):

(A) For spinal cord injury/dysfunction specialized centers and for blind rehabilitation specialized centers, the number of staffed beds and the number of full-time equivalent employees assigned to provide care at such centers.

(B) For prosthetics and sensory aids, the annual amount expended.

[(2)**]** *(4)* Not later than **[**April 1, 1999, April 1, 2000, and April 1, 2001**]** *April 1 of each year through 2004*, the Secretary shall sub-

mit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the Secretary's compliance, by facility and by service-network, with the requirements of this subsection. *The accuracy of each such report shall be certified by, or otherwise commented upon by, the Inspector General of the Department.*

[(3)**]** *(5)*(A) To ensure compliance with paragraph (1), the Under Secretary for Health shall prescribe objective standards of job performance for employees in positions described in subparagraph (B) with respect to the job performance of those employees in carrying out the requirements of paragraph (1). Those job performance standards shall include measures of workload, allocation of resources, and quality-of-care indicators.

* * * * * * *

[§ 1707. Restriction on use of funds for assisted suicide, euthanasia, or mercy killing]

§ 1707. Limitations

(a) Funds appropriated to carry out this chapter may not be used for purposes that are inconsistent with the Assisted Suicide Funding Restriction Act of 1997.

(b) The Secretary may furnish sensori-neural aids only in accordance with guidelines prescribed by the Secretary.

* * * * * * *

SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

§ 1710. Eligibility for hospital, nursing home, and domiciliary care

(a) * * *

* * * * * * *

(f)(1) * * *

(2) A veteran who is furnished hospital care or nursing home care under this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such care shall be liable to the United States for an amount equal to—

(A) * * *

(B) before September 30, **[**2002**]** *2007*, an amount equal to $10 for every day the veteran receives hospital care and $5 for every day the veteran receives nursing home care.

* * * * * * *

§ 1711. Care during examinations and in emergencies

(a) The Secretary may furnish hospital care incident to physical examinations where such examinations are necessary in carrying out the provisions of other laws administered by the Secretary.

[(b) The Secretary may furnish hospital care or medical services as a humanitarian service in emergency cases, but the Secretary shall charge for such care at rates prescribed by the Secretary.**]**

* * * * * * *

§ 1712A. Eligibility for readjustment counseling and related mental health services

(a) * * *

(b)(1) If, on the basis of the assessment furnished under subsection (a) of this section, a physician or psychologist employed by the Department (or, in areas where no such physician or psychologist is available, a physician or psychologist carrying out such function under a contract or fee arrangement with the Secretary) determines that the provision of mental health services to such veteran is necessary to facilitate the successful readjustment of the veteran to civilian life, such veteran shall, within the limits of Department facilities, be furnished such services on an outpatient basis. For the purposes of furnishing such mental health services, the counseling furnished under subsection (a) of this section shall be considered to have been furnished by the Department as a part of hospital care. Any hospital care and other medical services considered necessary on the basis of the assessment furnished under subsection (a) of this section shall be furnished only in accordance with the eligibility criteria otherwise set forth in this chapter (including the eligibility criteria set forth in section [1711(b)] *1784* of this title).

(2) Mental health services furnished under paragraph (1) of this subsection may, if determined to be essential to the effective treatment and readjustment of the veteran, include such consultation, counseling, training, services, and expenses as are described in [section 1701(6)(B)] *sections 1782 and 1783* of this title.

* * * * * * *

[§ 1714. Fitting and training in use of prosthetic appliances; seeing-eye dogs]

§ 1714. Fitting and training in use of prosthetic appliances; guide dogs; service dogs

(a) * * *

(b) The Secretary may provide [seeing-eye or] guide dogs trained for the aid of the blind to veterans [who are entitled to disability compensation, and may pay travel and incidental expenses (under the terms and conditions set forth in section 111 of this title) to and from their homes and incurred in becoming adjusted to such seeing-eye or guide dogs] *who are enrolled under section 1705 of this title*. The Secretary may also provide such veterans with mechanical or electronic equipment for aiding them in overcoming the [handicap] *disability* of blindness.

(c) The Secretary may, in accordance with the priority specified in section 1705 of this title, provide—

(1) service dogs trained for the aid of the hearing impaired to veterans who are hearing impaired and are enrolled under section 1705 of this title; and

(2) service dogs trained for the aid of persons with spinal cord injury or dysfunction or other chronic impairment that substantially limits mobility to veterans with such injury, dysfunction, or impairment who are enrolled under section 1705 of this title.

(d) In the case of a veteran provided a dog under subsection (b) or (c), the Secretary may pay travel and incidental expenses for that

veteran under the terms and conditions set forth in section 111 of this title to and from the veteran's home for expenses incurred in becoming adjusted to the dog.

* * * * * * *

SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

* * * * * * *

§ 1722. Determination of inability to defray necessary expenses; income thresholds

(a) For the purposes of section 1710(a)(2)(G) of this title, a veteran shall be considered to be unable to defray the expenses of necessary care if—

(1) * * *

* * * * * * *

(3) the veteran's attributable income is not greater than the [amount set forth in] *income threshold determined under* subsection (b).

[(b)(1) For purposes of subsection (a)(3), the income threshold for the calendar year beginning on January 1, 1990, is—

[(A) $17,240 in the case of a veteran with no dependents; and

[(B) $20,688 in the case of a veteran with one dependent, plus $1,150 for each additional dependent.

[(2) For a calendar year beginning after December 31, 1990, the amounts in effect for purposes of this subsection shall be the amounts in effect for the preceding calendar year as adjusted under subsection (c) of this section.]

(b)(1) For purposes of subsection (a)(3), the income threshold applicable to a veteran is the amount determined under paragraph (2).

(2) The amount determined under this paragraph for a veteran is the greater of the following:

(A) For any calendar year after 2000—

(i) in the case of a veteran with no dependents, $23,688, as adjusted under subsection (c); or

(ii) in the case of a veteran with one or more dependents, $28,429, as so adjusted, plus $1,586, as so adjusted, for each dependent in excess of one.

(B) The amount in effect under the HUD Low Income Index that is applicable in the area in which the veteran resides.

(3) For purposes of paragraph (2)(B), the term "HUD Low Income Index" means the family income ceiling amounts determined by the Secretary of Housing and Urban Development under section 3(b)(2) of the United States Housing Act of 1937 (42 U.S.C. 1437a(b)(2)) for purposes of the determination of "low-income families" under that section.

(c) Effective on January 1 of each year, the amounts in effect under subsection (b)*(2)(A)* of this section shall be increased by the percentage by which the maximum rates of pension were increased

under section 5312(a) of this title during the preceding calendar year.

* * * * * * *

§ 1729. Recovery by the United States of the cost of certain care and services

(a)(1) * * *

(2) Paragraph (1) of this subsection applies to a non-service-connected disability—

(A) * * *

* * * * * * *

(E) for which care and services are furnished before October 1, **[**2002**]** *2007*, under this chapter to a veteran who—

(i) has a service-connected disability; and

(ii) is entitled to care (or payment of the expenses of care) under a health-plan contract.

* * * * * * *

(f) No law of any State or of any political subdivision of a State and no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section or with respect to care or services furnished under section **[**1711(b)**]** *1784* of this title.

* * * * * * *

§ 1729A. Department of Veterans Affairs Medical Care Collections Fund

(a) * * *

(b) Amounts recovered or collected after June 30, 1997, under any of the following provisions of law shall be deposited in the fund:

(1) * * *

* * * * * * *

(7) Section 1784 of this title.

[(7)**]** *(8)* Public Law 87–693, popularly known as the "Federal Medical Care Recovery Act" (42 U.S.C. 2651 et seq.), to the extent that a recovery or collection under that law is based on medical care or services furnished under this chapter.

* * * * * * *

SUBCHAPTER VIII—HEALTH CARE OF PERSONS OTHER THAN VETERANS

[§ 1713.] ***§ 1781.*** **Medical care for survivors and dependents of certain veterans**

(a) * * *

(b) In order to accomplish the purposes of subsection (a) of this section, the Secretary shall provide for medical care in the same or similar manner and subject to the same or similar limitations as medical care is furnished to certain dependents and survivors of active duty and retired members of the Armed Forces under chapter 55 of title 10 (CHAMPUS), by—

(1) * * *

* * * * * * *

In cases in which Department medical facilities are equipped to provide the care and treatment, the Secretary is also authorized to carry out such purposes through the use of such facilities not being utilized for the care of eligible veterans. *A dependent or survivor receiving care under the preceding sentence shall be eligible for the same medical services as a veteran, including services under sections 1782 and 1783 of this title.*

* * * * * * *

§ 1782. Counseling, training, and mental health services for immediate family members

(a) COUNSELING FOR FAMILY MEMBERS OF VETERANS RECEIVING SERVICE-CONNECTED TREATMENT.—In the case of a veteran who is receiving treatment for a service-connected disability pursuant to paragraph (1) or (2) of section 1710(a) of this title, the Secretary shall provide to individuals described in subsection (c) such consultation, professional counseling, training, and mental health services as are necessary in connection with that treatment.

(b) COUNSELING FOR FAMILY MEMBERS OF VETERANS RECEIVING NON-SERVICE-CONNECTED TREATMENT.—In the case of a veteran who is eligible to receive treatment for a non-service-connected disability under the conditions described in paragraph (1), (2), or (3) of section 1710(a) of this title, the Secretary may, in the discretion of the Secretary, provide to individuals described in subsection (c) such consultation, professional counseling, training, and mental health services as are necessary in connection with that treatment if—

(1) those services were initiated during the veteran's hospitalization; and

(2) the continued provision of those services on an outpatient basis is essential to permit the discharge of the veteran from the hospital.

(c) ELIGIBLE INDIVIDUALS.—Individuals who may be provided services under this subsection are—

(1) the members of the immediate family or the legal guardian of a veteran; or

(2) the individual in whose household such veteran certifies an intention to live.

(d) TRAVEL AND TRANSPORTATION AUTHORIZED.—Services provided under subsections (a) and (b) may include, under the terms and conditions set forth in section 111 of this title, travel and incidental expenses of individuals described in subsection (c) in the case of—

(1) a veteran who is receiving care for a service-connected disability; and

(2) a dependent or survivor receiving care under the last sentence of section 1783(b) of this title.

§ 1783. Bereavement counseling

(a) DEATHS OF VETERANS.—In the case of an individual who was a recipient of services under section 1782 of this title at the time of

the death of the veteran, the Secretary may provide bereavement counseling to that individual in the case of a death—

(1) that was unexpected; or

(2) that occurred while the veteran was participating in a hospice program (or a similar program) conducted by the Secretary.

(b) DEATHS IN ACTIVE SERVICE.—The Secretary may provide bereavement counseling to an individual who is a member of the immediate family of a member of the Armed Forces who dies in the active military, naval, or air service in the line of duty and under circumstances not due to the person's own misconduct.

(c) BEREAVEMENT COUNSELING DEFINED.—For purposes of this section, the term "bereavement counseling" means such counseling services, for a limited period, as the Secretary determines to be reasonable and necessary to assist an individual with the emotional and psychological stress accompanying the death of another individual.

§ 1784. Humanitarian care

The Secretary may furnish hospital care or medical services as a humanitarian service in emergency cases, but the Secretary shall charge for such care and services at rates prescribed by the Secretary.

* * * * * * *

PART V—BOARDS, ADMINISTRATIONS, AND SERVICES

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CHAPTER 73—VETERANS HEALTH ADMINISTRATION—ORGANIZATION AND FUNCTIONS

* * * * * * *

§ 7305. Divisions of Veterans Health Administration

The Veterans Health Administration shall include the following:

(1) * * *

* * * * * * *

(7) A Chiropractic Service.

[(7)**]** *(8)* Such other professional and auxiliary services as the Secretary may find to be necessary to carry out the functions of the Administration.

§ 7306. Office of the Under Secretary for Health

(a) The Office of the Under Secretary for Health shall consist of the following:

(1) * * *

* * * * * * *

(7) A Director of Chiropractic Service, who shall be a qualified doctor of chiropractic and who shall be responsible to the Secretary for the operation of the Chiropractic Service.

[(7)**]** *(8)* Such directors of such other professional or auxiliary services as may be appointed to suit the needs of the De-

partment, who shall be responsible to the Under Secretary for Health for the operation of their respective services.

[(8)] *(9)* The Director of the National Center for Preventive Health, who shall be responsible to the Under Secretary for Health for the operation of the Center.

[(9)] *(10)* The Advisor on Physician Assistants, who shall be a physician assistant with appropriate experience and who shall advise the Under Secretary for Health on all matters relating to the utilization and employment of physician assistants in the Administration.

[(10)] *(11)* Such other personnel as may be authorized by this chapter.

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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY; ENHANCED–USE LEASES OF REAL PROPERTY

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SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

* * * * * * *

§ 8111. Sharing of Department and Department of Defense health-care resources

(a) * * *

* * * * * * *

(g) For the purposes of this section:

(1) * * *

* * * * * * *

(4) The term "health-care resource" includes hospital care, medical services, and rehabilitative services, as those terms are defined in paragraphs (5), (6), and (8), respectively, of section 1701 of this title, *services under sections 1782 and 1783 of this title* any other health-care service, and any health-care support or administrative resource.

(5) The term "primary beneficiary" (A) with respect to the Department means a person who is eligible under this title (other than under [section 1711(b) or 1713] *section 1782, 1783, or 1784* or subsection (d) of this section) or any other provision of law for care or services in Department medical facilities, and (B) with respect to the Department of Defense, means a member or former member of the Armed Forces who is eligible for care under section 1074 of title 10.

* * * * * * *

§ 8111A. Furnishing of health-care services to members of the Armed Forces during a war or national emergency

(a)(1) * * *

(2) For the purposes of this section, the terms "hospital care", "nursing home care", and "medical services" have the meanings given such terms by sections 1701(5), 101(28), and 1701(6) of this title, respectively*, and the term "medical services" includes services under sections 1782 and 1783 of this title*.

* * * * * * *

SUBCHAPTER IV—SHARING OF MEDICAL FACILITIES, EQUIPMENT, AND INFORMATION

* * * * * * *

§ 8152. Definitions

For the purposes of this subchapter—

(1) The term "health-care resource" includes hospital care and medical services (as those terms are defined in section 1701 of this title), *services under sections 1782 and 1783 of this title,* any other health-care service, and any health-care support or administrative resource.

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CHAPTER 85—DISPOSITION OF DECEASED VETERANS' PERSONAL PROPERTY

* * * * * * *

SUBCHAPTER I—PROPERTY LEFT ON DEPARTMENT FACILITY

* * * * * * *

§ 8502. Disposition of unclaimed personal property

(a) * * *

(b) If any veteran (admitted as a veteran), or a dependent or survivor of a veteran receiving care under **[**the last sentence of section 1713(b)**]** *the penultimate sentence of section 1781(b)* of this title, upon such person's last admission to, or during such person's last period of maintenance in, a Department facility, has personal property situated on such facility and shall have designated in writing a person (natural or corporate) to receive such property when such veteran, dependent or survivor dies, the Secretary or employee of the Department authorized by the Secretary so to act, may transfer possession of such personal property to the person so designated. If there exists no person so designated by such veteran, dependent, or survivor or if the one so designated declines to receive such property, or failed to request such property within ninety days after the Department mails to such designate a notice of death and of the fact of such designation, a description of the property, and an estimate of transportation cost, which shall be paid by such designate if required under the regulations hereinafter mentioned, or if the Secretary declines to transfer possession to such designate, possession of such property may in the discretion of the Secretary

or the Secretary's designated subordinate, be transferred to the following persons in the order and manner herein specified unless the parties otherwise agree in writing delivered to the Department, namely, executor or administrator, or if no notice of appointment received, to the spouse, children, grandchildren, parents, grandparents, siblings of the veteran. If claim is made by two or more such relatives having equal priorities, as hereinabove prescribed, or if there are conflicting claims the Secretary or the Secretary's designee may in such case deliver the property either jointly or separately in equal values, to those equally entitled thereto or may make delivery as may be agreed upon by those entitled, or may in the discretion of the Secretary or the Secretary's designee withhold delivery from them and require the qualification of an administrator or executor of the veterans' estate and thereupon make delivery to such.

* * * * * * *

SUBCHAPTER II—DEATH WHILE INMATE OF DEPARTMENT FACILITY

§ 8520. Vesting of property left by decedents

(a) Whenever any veteran (admitted as a veteran), or a dependent or survivor of a veteran receiving care under **[**the last sentence of section 1713(b)**]** *the penultimate sentence of section 1781(b)* of this title, shall die while a member or patient in any facility, or any hospital while being furnished care or treatment therein by the Department, and shall not leave any surviving spouse, next of kin, or heirs entitled, under the laws of the decedent's domicile, to the decedent's personal property as to which such person dies intestate, all such property, including money and chooses in action, owned by such person at the time of death and not disposed of by will or otherwise, shall immediately vest in and become the property of the United States as trustee for the sole use and benefit of the General Post Fund (hereinafter in this subchapter referred to as the "Fund"), a trust fund prescribed by section 1321(a)(45) of title 31.

* * * * * * *

§ 8521. Presumption of contract for disposition of personalty

The fact of death of a veteran (admitted as such), or a dependent or survivor of a veteran receiving care under **[**the last sentence of section 1713(b)**]** *the penultimate sentence of section 1781(b)* of this title, in a facility or hospital, while being furnished care or treatment therein by the Department, leaving no spouse, next of kin, or heirs, shall give rise to a conclusive presumption of a valid contract for the disposition in accordance with this subchapter, but subject to its conditions, of all property described in section 8520 of this title owned by said decedent at death and as to which such person dies intestate.

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